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Journal

*of the association for physical
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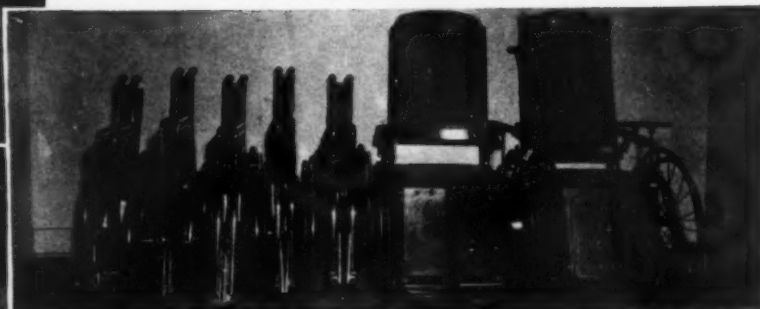
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AN EXPLORATORY TRAINING TECHNIQUE FOR THE RE-EDUCATION OF CATATONICS

by

PAUL ROLAND

Chief Corrective Therapy, Danville, Illinois

With the ever increasing population in our Veterans Psychiatric Hospital, and the inability to give individually adequate treatment to all, there has been a great martialling of new techniques, some formerly applied, others new manifestations of older practices and some relatively new. The Corrective Therapy Department of the Danville Veterans Administration Hospital, working under the direction and in the closest cooperation with the ward psychiatrist, formulated a new procedure for treatment of catatonic patients with encouraging results. The initial experiment, based on a catatonic group, indicated a role of Educational Therapy, as well. Corrective Therapy and Educational Therapy formed an integrated team in carrying out these new procedures. The techniques used were susceptible to group methods.

It was decided to apply these techniques to catatonic schizophrenics because many of these abilities present nursing problems in the mental hospital. The neglect of attention to even the basic needs of life by the patient, results in the need for costly nursing procedures to maintain his physical condition even marginally.

Regardless of the mixtures used in tube feeding and other methods of food

administration, the catatonic often emerges from his relapse in a physically weak state. In consideration of the present unit cost of labor, assignment of nurse and attendant personnel to such patients requires a maintenance of a very expensive nature. Therefore, any technique which can shorten the period of relapse and speed up the remission, may be of great value, both to the patient and to the institution. So far, our techniques have not been used in conjunction with shock therapy, although such a series may be treated later. The group treated, has been composed of men of World War II, ranging from 18 to 30 years of age. None of the group has suffered physical disabilities worthy of note. The average educational level was that of high school.

The program was so set up to combine known Corrective Therapy techniques with simple suitable phases of Educational Therapy, which were divided into two distinct phases of the program for each veteran. The sessions or classes were set up on a 5-day week basis and each class was conducted for a full 2 hour period. At the outset, the efforts were exploratory in nature.

The group exhibited the following general behavior characteristics. The

most noteworthy was their lack of external response, either through action or words, to stimuli. The group was entirely uncommunicative. There was a common lack of ability to perform even the simplest of skilled acts, like drawing a straight line on a piece of paper or tying a knot. Again we noted another group similarity in their inability to relax in any normal degree.

It was decided the first objective in the treatment of the patient was a relaxation technique. This we called the relaxation response technique. In this procedure patients were placed on the relaxation table and various methods were used to obtain conscious relaxation. The instructor first moves the patient's arm passively and urges him to relax. The patient gradually will allow unrestricted movements to take place without muscular effort and offers no resistance to the gravitational drop or release of the part. The next important step and the most difficult is obtaining free movement of the mouth and relaxation of the larynx. This requires individual encouragement. Free movement of the mouth and relaxation of the muscles of larynx and tongue are very important.

Verbal response and concentration on external activity is our first objective. In the majority of these cases the tongue is curled up against the roof of the mouth.

In order to obtain verbal response it is first necessary to get the patient to move his mouth freely and push his tongue out. This procedure is important in obtaining first verbal responses. In this technique, the patient relaxes on the table as the instructor, in a low, understanding voice, speaks to him, using phrases like "I am here to help you. I know that you have trouble talking but if you will follow my instructions, I will help you," etc. As the patient relaxes under the soothing drone of the instructor's voice his arms are moved passively. As the exercises progress the instructor asks the patient to try simple sounds such as "oh," "ah," "oo", each being encouraged for as much as 5 minutes. As the patient re-

laxes and makes satisfactory audible sounds, he is urged to try simple words like "dog" and "cat." If he indicates that he cannot or will not say them, he is urged to think them and move his lips as if he were speaking. Efforts become audible when these words are discernable in the strained expression and moving lips. Success in spoken words is given generous praise. Expressions of praise frequently given seem to be understood and appreciated by the patient.

A combination of vibration and forced respiration has proven effective in obtaining initial verbal responses. This technique should only be used in later stages of relaxation therapy when patients' expressions indicate he is cooperating but is unable to release hypertension.

The vibrator is first applied to the larynx followed by a combination of forced respiration. The therapist then applies vibration to the mouth with the tongue compressor. The hand vibrator provides the vibration that is administered through the tongue compressor.

Several of our patients we have treated have not talked for many years. One of our recent patients is talking for the first time since November 1943. Treatment was instituted on January 5, 1948 and after intensive therapy began talking again March 30, 1948. Two of our patients that have returned home are working here in St. Louis.

After the patient begins to talk again the instructor teaches concentration in connection with the relaxation technique. The patient is asked questions like: Where is your home? What is the month? What Hospital are you in? and etc. The questions become a little more complicated as the patient begins to verbalize his orientation to time and place and is able to recall things. The recalling of traumatic experiences many times produces muscular rigidity and whenever possible this is avoided. A patient is often given a newspaper while on the relaxation table and is asked to read an article. The instructor then

asks the patient what he has read. In the majority of cases he does not recall what he has read but soon learns to concentrate on what he is reading under the guidance of the instructor.

Relaxation Response Techniques have proven valuable in feeding problems. One patient was assigned to Catatonic Research Clinic on June 24, 1947, with a statement from his doctor to the effect that he would not eat, had to be fed, and during a previous period had to be tube fed.

Relaxation response therapy started on June 24th with the following results. 1st day, forced feeding was required and no noticeable results. 2nd day, forced feeding was required; would drink milk voluntarily. 3rd day forced feeding was required. 4th day, ate fairly well, part voluntarily, part by forced feeding. 5th day, ate double helpings of everything for breakfast. Continued to eat other meals unassisted. Recheck on 8th day showed he had continued to eat voluntarily. Attendants report he not only eats what he is given but additional food in some instances. Patient is continuing therapy and is much more alert, active, and responsive as to time, place and past since therapy has been instituted.

In the series treated, supplementing the relaxation technique suggestive association was used. In this phase, 4 men were taken in 2 pairs, and grouped in a circle. The instructor took his position in the center of the circle with a volley ball in hand.

The instructor passed the ball to each patient, and urged him to say the word "ball", and in turn pass or toss the ball to the patient at his left, and so on until the ball had passed completely around the circle. The result was slow, clumsy, and discouraging. Some of the patients couldn't catch, handle, or pass the ball, much less call it by name. Soon, through the persistent efforts of the instructor, all of the patients were performing the exercise in a creditable manner. Not only did they respond to the power of suggestion, by calling out the name "ball" as it came to them, but they seemed also

to develop a spirit of alertness. It became evident that various members of the group had played soccer, basketball, or volley ball. The soccer player passed the ball by bouncing it off his head, and the basketball player made quick underhand or overhead passing shots while the volley ball player passed it by using a two handed push shot to his receiver.

Two of the men, slower in responding to suggestion, preferred to hold the ball, fondling it, turning it in their hands, appearing not able to recognize it or call it by name. Weather permitting, the ball therapy was continued out-of-doors for the full period of the experiment. Definite week-by-week improvement in response to suggestion and concentration was noted.

Simultaneously with the relaxation technique, known principles of Educational Retraining were started with the group. Here again the plan was to work with the men in pairs—though often, if attention levels could be maintained, two pairs, or four men, were under the friendly supervision of the instructor.

Striving for recognition of shape, size, design, color, and utilitarian value of common objects, we arrayed pencils and paper, cards bearing common geometric designs, spools, cones, cylinders, art objects, and elementary reading material on a work table where it would command point-of-interest attention.

All of these devices were quickly recognized by name. However art objects and drawings made less impression and evoked no particular interest.

Progress was rapid with the card designs and other objects used, and the sorting of spools, cones, and design bearing cards into proper categories of shape, size and color served to develop concentration and permitted them to become better acquainted with their instructors instead of resenting or fearing them.

Surprisingly, the pencil and paper device proved of greatest interest. And as the experiment progressed, deemed to offer the greatest promise in terms of patient response.

Once the fear of being asked to sign something—was dissipated, their reaction was spontaneous and sustained.

When a patient displayed interest in pencil and paper, the instructors started passive work on numbers from 1 to 10. As soon as the concentration response became apparent and a patient could write 1-2-3, he was encouraged to go ahead on his own. Each succeeding day they were urged to continue their number writing as far as they could carry it.

In some instances a man would write down only the numbers up to 25. Another, to 100-200 and so on. Then numbers were dictated to them—up to 100.

Then, as the next step, simple problems of arithmetic, such as addition, subtraction and multiplication were attempted, passively and actively. The results were encouraging, both in response and ability to sustain attention. At this point, somewhere in the 2nd week, drills in addition and multiplication were started with flash cards. This was done in order to secure an oral response on the part of the patients. At first only individual response to the drill was noted. As the assignment became increasingly complex, group attention and group response were attained.

Concurrently in this period, simple hand writing techniques, passively induced, was begun.

Continuous straight lines, free hand circles and ovals constituted the primary effort. Again as each patient responded and became able to sustain activity in these exercises, he was assigned more complex tasks.

At the outset of the lesson period each patient was asked to write his name and the date at the top of the page. From this he progressed to a full set of writing exercises copying from Writing Practice of the Copy Book. Also words and sentences were dictated and written. In writing, frequent use was made of their names, date, home addresses, time of year, points of interest and their own localities, and local geographic facts. This was done for the purpose of establishing a reintegration of reality with old, formulated

associations.

Well along in the experiment, the instructor purposely gave a patient a wrong date. He was immediately corrected, while the patients, with smiles and laughter, enjoyed a joke at the instructor's expense. Near the close of the experiment simple tests were devised and given.

These consisted primarily of word matching, term matching, circling words containing similar letters, circling words beginning with the letter "a," matching opposite words like "Yes" and "No", "Rain" and "Shine"—and many others.

Finally the men were encouraged to write letters to their family and friends.

Suggested phrases like: "I am going to get well," "Mr. Taylor and Mr. Roland are here to help me," "I am improving," "My memory is better," "I am spelling better," also were used. Some of these letters were quite revealing. They showed definite improvement in relaxation concentration and sustained attention.

The following letter was written by one of our patients who had received intensive therapy. This patient previously was apparently disoriented as to time and place and at this time is making an excellent adjustment. He received no assistance from instructors in writing this letter.

Dear Mom and Dad:

Hope you are both feeling fine. I haven't had much of a chance to write letters lately what with my sitting on the ward and my rehabilitation activities. I really didn't want to write this letter but here I am writing it so I suppose from now on I spend some of my time writing to you. It seems quite a while since I've written you. I can't seem to remember things that have happened the past few months but I don't suppose they have much to do anyway. I am feeling better lately.

Your son James

Eighty-seven patients have completed treatment in the clinic since April 15, 1947. Sixty-four patients have been advanced to higher therapy, fourteen have returned home and 9 received no results, the majority of which were mental deficient. Thirty-two patients are still

receiving treatment. There is marked improvement in all from the standpoint of verbalization, relaxation, orientation as to time and place and concentration.

Sixty-four patients have been assigned to Manual Arts Therapy sections and details. It has appeared advisable at first to assign patients to the shops or details on a half day basis and continue the relaxation response activities the remainder of the time. Reports are sent back from the shops and elsewhere concerning his progress. If the progress report shows he is making a satisfactory adjustment relaxation response activities are discontinued. In the event of a relapse the patient is immediately sent back to the clinic. There have been two patients returned for further treatment thus far.

In conclusion I would like to point out a few pertinent points which may serve as a guide in contemplated corrective measures of this nature—points which developed as the experiment proceeded.

1. Patience and alertness are necessary on the part of the instructor in adjusting the techniques to meet the needs of the individual patient.
2. The development of ability to sustain attention is a primary goal.
3. Pencil work may very well be offered early in the experiment, provided it consists of simple assignments, such as writing small numbers as dictated—and progressing to simple addition and multiplication.
4. The use of devices calling for oral response are indicated and effective. Flash cards fall in this category.
5. Reading aloud, in the later stages of the experiment is feasible but only if and when attention can be sustained.
6. Conversation should center around associations of time, dates, places and situations in testing recall activities. Recalling military experiences or situations that are painful should be avoided.
7. Study of a patient's background gives important clues that aid in bringing him back to reality.
8. Relaxation therapy techniques are important in developing a strong interpersonal relationship between instructor and patient.

AN EXPLORATORY TRAINING TECHNIQUE USING A GROUP PROCEDURE FOR RELAXATION

by

EARL W. MASON, Chief Corrective Therapy

EDWARD Z. KOSKI, Corrective Therapist

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This is a discussion of a procedure for giving relaxation and relaxation training, as adapted to a particular situation and under conditions encountered, in a certain Corrective Therapy Program. The values of relaxation, as training or treatment, are well known and have been generally accepted.

This procedure has been used successfully in this situation for the past two years. Relaxation training has been given to two or three different groups each day. Approximately 850 group periods have been totalled, over 6,500 treatments have been recorded, and more than 1,000 patients have received it. The average number for the groups was about eight and groups have numbered as few as three and as many as thirty. Two therapists were obliged to work with the larger groups to obtain proper results and effectiveness.

The procedure has been evaluated several times. Dr. Donald Moore, Chief of the Neuropsychiatric Service, and Dr. Harlen Parker, Chief of the Acute Treatment Section, endorse and recommend it as an effective therapeutic adjunct. It is felt by them that this program represents a real contribution enlarging the field of group therapy to include this rehabilitation department. Dr. Joshua Ehrlich, Chief, Physical

Medicine Rehabilitation here has approved it and Dr. John Eisele Davis, Chief of Corrective Therapy, Wash., D.C., comments that he thinks it an important piece of exploratory work and that the conclusions, in the main, appear to be sound and the approach effective.

Relaxation was prescribed, by the doctors, as a phase of treatment and rehabilitation, for hospital patients whose case histories indicated it would be beneficial. These prescriptions were for patients with specific speech difficulties, nervous, digestive, respiratory, cardiac, and circulatory ailments as well as specific organic, systemic, muscular, other disturbances; or a great many of these were patients from the neuropsychiatric service. The number of patients prescribed relaxation and the length of time needed to give it became so great that relaxation given on an individual basis required the attention of two corrective therapists each day for this phase of the program.

The procedure was thus changed, out of necessity, and relaxation was given to a number of patients at the same time on a group basis. It was then possible to treat the patients prescribed to this phase through the services of one therapist, and in approximately two hours.

The results noted and the indications in patient progress under these new conditions seemed to justify continuance of the group procedure. When specific individual attention was not indicated for a patient, he was assigned to a group for relaxation. Sometimes as many as 24 have been assigned regularly to a group for instruction. Even though relaxation using this procedure was apparently as beneficial, or nearly so, as that received individually, it was changed by prescription of the doctor to *Relaxation Training* when given in this manner.

In general, the results were found to be very satisfactory. The principles and techniques used and the conditions maintained were as parallel to those of individual procedure as possible. Edmund Jacobson's and Josephine Rathbone's ideas and procedures for progressive relaxation to relieve tension, localized and general, were particularly useful. Contrary to what was expected with a procedure varying from the individual method, in many respects beneficial results could be noted. Included among these were the following:

1. Patients were not as self conscious, when in a group during relaxation, and therefore responded better and quicker.

(1) Edmund Jacobson, *Progressive*

Published with permission of the Chief Medical Director, Department of Medicine and Surgery, Veterans Administration who assumes no responsibility for the opinions expressed or the conclusions drawn by the author.

Relaxation, University of Chicago Press, Chicago, Illinois, 1946.

(2) Josephine Rathbone, *Relaxation*, Teachers, College Columbia University, N. Y. Bureau of Publications, New York, 1943.

2. A spirit of companionship entered and psychological conditions were such that the patient was more receptive of the treatment and general effectiveness was increased.

3. The patient did not feel that he was, so sick, that he needed special attention apart from others, which was psychologically encouraging.

4. Instruction and advice repeated to others of the group, and over and over several times, was of benefit to all members through repetition.

5. The patients could watch actual demonstrations by the others and imitate the actions. This made it easier to get certain facts and points of instruction across to them.

6. The value of relaxation and relaxation training was accentuated by the fact that so many others were taking it and the patient readily accepted that value.

7. The patients could note and observe the benefits to others and exchange testimonials of their progress and the results noted.

8. In consideration of the specific, emotional, and psychological needs, especially of the neuropsychiatric patients, the results were judged to be more satisfactory than those obtained through individual relaxation.

9. The influence of group relations and pressures offered a situation for helping with proper adjustment of the individual to others.

10. It enabled the therapist to exert more influence and proper direction through his predominating leadership in relationships with the patients and with the position he had assumed in their estimate because of his participation and standing in other phases of the program.

These points are stressed in the mechanics used and the procedure followed in giving relaxation training.

1. Be sure that each patient is comfortable in a supine position on a comfortably broad and padded surface. Use towels or pillows to relieve excessive tension that may interfere with relaxation of certain joints or areas. Instruct the patient to let himself "sink through the mattress."

2. Instruct the patient to concentrate on some very pleasant imaginary outdoor scene of blue skies, sunshine, expansive water, or warm grass.

3. Deep and slow breathing should be encouraged to simulate conditions in sleep or of rest.

4. Each patient is given individual attention and treatment within the group.

5. Test each patient for parts with excessive tension and bring this fact to his attention so specific concentration and effort can be applied to overcome it. Tests are made by passive movement of parts or by touching the muscles involved, with the fingers, in search of tensed or rigid muscular condition. The following joints and surrounding areas are tested; shoulder girdle area near the spine, shoulders, elbows, wrists, upper trunk, lower trunk, pelvic region, hips, knees, ankles, neck, jaws, cheeks, mouth, eyes, and forehead. Test anteriorly and posteriorly to areas.

6. Exercises should be accompanied by setting of the muscles involved, the most strenuous should be given first and include; shoulder elevation and shrugs, trunk raising and lowering, back arches, pelvic tilts, hip elevation and shrugs, buttock squeezes, leg rotation laterally and medially, muscle setting of the entire body putting the body weight on the heels and the back, elevation of the arms above the head, elbow flexion and extension, fist clenching, lifting and turning of the head, and muscle setting of the muscles of the neck and face. Each exercise is done slowly with muscles tense and afterward an attempt is made to relax and rest the parts involved in that move-

(Continued on page 8)

NEWS

Bernard Berner, Executive Assistant, Physical Medicine Rehabilitation Service, reports on rehabilitation highlights, from Castle Point, N. Y. —

Money for a Tuberculosis Rehabilitation Building has been appropriated. Construction of this new building will be commenced within the next few months. — Castle Point will be the first Tuberculosis Hospital in the Veterans Administration to establish a regular Rehabilitation Ward. A program for patients on this new ward is now in readiness for use.

Dr. J. Goldberg, (Chief, Physical Medicine Rehabilitation Service), Bernard Berner, (Executive Assistant, Physical Medicine Rehabilitation Service), and J. O'Keefe, (Chief, Vocational Rehabilitation and Education), are completing an article for early publication on the function of the Medical Rehabilitation Board in a Tuberculosis hospital.

Our Manual Arts Therapy Section continues to lead the way in Light Mechanics, under the very able tutelage of Chief S. Schweber. It is expected that other M. A. T. therapists will report here, as in the past, for a brief course in Light Mechanic techniques which can be utilized for patients in their hospitals. — Dr. M. Cooper, who reported here recently, is the first Clinical Psychologist to be assigned for full time duty to a tuberculosis hospital. His work in treating emotional problems of Tuberculosis patients is of first-rate importance to the doctors and to the Physical Medicine Rehabilitation Service — Broadcasts utilizing the hospital-wide WBRS (Bed-Rest Station) are a regular feature of communicating rehabilitation information directly to the patients on infirmary wards.

(Continued on page 25)

(Continued from page 7)

ment. The purpose is to develop awareness of the difference between a tensed and relaxed condition. A condition is also produced which demands that relaxation and rest follow prolonged muscle strain.

7. Specific exercises, postures, and positions are shown for the relief of tension from positions of prolonged strain, such as vocational postures or structural posture deviations.

8. Instructions and directions given by therapists should be in a monotone with the voice low, soft, and pleasing in sound. Words should be repeated several times autosuggestively and slowly to produce a languid, well relaxed condition in the patient. Each exercise should be repeated two or three times.

9. Its value and the application and practice in the many various situations and under conditions of everyday life must be stressed emphatically. The patient must be impressed to relax and rest every possible muscle group when tension, strain, and action are not necessary. He must be shown that he can rest parts of the body while other parts might be in action. He must be taught that he can relax to some extent in any position whether it be standing, stooping, squatting, sitting, or reclining and that occasional changes in position relieve strain and are restful. The patient must be trained to break habits resulting in muscle and mental tension and nervous movements that, though insignificant at the moment, if continued over a long period will cause fatigue. Relaxation, practiced while trying to go to sleep, will encourage sleep and contribute to better rest while sleeping.

The mechanics of the group procedure are as follows:

"Make yourselves as comfortable as possible. Move around until you feel just right, now let yourself "go limp". Select an object far away and watch it, or close your eyes lightly and relax. Breathe deeply, then expel the air as in a sigh of relief, and relax. Breathe deeply, slowly, and relax.

Think of, and picture in your mind, some pleasant outdoor scene of soft warm grass, warm sunny expanses, blue skies, green fields, large expanses of water, or some other agreeable scene.

Now, lift your shoulders, high, then let them drop, and relax. Start to sit up, raise the trunk about 6 inches, and lower slowly, then relax. Arch the back then bridge the body slightly with the weight on the heels and the shoulders, lower weight slowly then relax. Turn the feet inward and try to touch the toes together, then relax the legs and hips, rest. Now, clench your fists, tight, tight, tight, breathe deeply, slowly, and then let yourself relax. Let yourself go completely. Now, clench your fists tight, bring your fists up to the chest, press hard, then lower fists slowly, and relax. Now, try to sleep, keep your eyes closed and let your body slump "limply". Clench your fists tightly, lift your arms straight and high, high, higher, breathe deeply, slowly, lower arms, and relax, expelling breath. Rest, relax, and rest, try to go to sleep. Squeeze the buttocks together, tightly, then relax. Let the head roll from side to side and relax the neck muscles, press head against mat, tighten neck muscles and relax. Tighten mouth, cheek, eye, and forehead muscles by squinting, then let them relax. Now, breathe deeply and slowly and try to go to sleep. (Each step above should be repeated two or three times before passing to another step.)

The entire procedure should take about twenty to thirty minutes. A deep sleep will follow in many instances or signs following a deep sleep will be noticeable in most patients. It has been signs following deep sleep will be observed that signs, indicating tension and nervousness, have decreased or subsided with the progression of relaxation and relaxation training. It should be clearly understood that few people know how to relax until they have been shown and adequately instructed.

In summary, it should be stated that this procedure has been used successfully for the past two years in this situation.

It has involved a large number of patients, many of whom have shown definite improvement that can be contributed directly to this group procedure.

It has been evaluated, approved, and judged to be basically sound and effective by a number of medical authorities and psychiatrists.

Numerous man hours of time have been saved and it has been possible to treat a larger number of patients than would have been possible with the limited personnel.

It has proven to be of value to patients with many types and varieties of ailments.

It has definite value as relaxation treatment and at the same time offers training in other phases of relaxation needs.

It is felt that such training has possibilities as a preventive, as well as a carry over value upon return home.

THE END

TO OUR READERS

This is YOUR publication.

We are depending upon YOU to keep it readable and interesting. If you know of items of a professional or personal nature which you believe worthy of publication, let us have them.

Remember that the "Journal" is designed primarily for YOU . . . to keep you in closer touch with your fellow therapists throughout the country, to let them know what you are thinking and doing and to tell you what they are doing.

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NEW PROGRAM PROVIDES AID FOR PHYSICALLY HANDICAPPED

Burke Foundations Mobility, Inc., Places

Emphasis on Activity, Not Rest

by HOWARD A. RUSK, M.D.

Reprinted from N. Y. TIMES, July 24, 1949

Surrounded by rolling lawns and beautiful trees, the trim red-brick colonial buildings of the Burke Foundation in White Plains have for many years served convalescent patients from Westchester County and New York City. Either without cost or on a part-pay basis, hundreds of men and women have benefited from several weeks of rest there after medical or surgical treatment.

Today, on the first floor of Hewitt Cottage, there is a new program in which emphasis is placed on activity instead of rest. This program is known as Mobility, Inc., an out-patient center for rehabilitation training for the physically handicapped.

Mobility, Inc., has been open less than six months, but behind it is almost twenty years of planning. Relieved from many of their wartime responsibilities, the Scarsdale Junior League determined early in 1947 that in addition to providing trained volunteers for community services it should undertake a comprehensive survey of the problems of the handicapped of Westchester.

From this survey it was apparent that the greatest need was for a rehabilitation training center. Disabled Westchester County persons seeking rehabilitation were found to be forced to go to New York City, the New York State Rehabilitation Hospital at West Haverstraw or the workshop of the Connecticut Society for Crippled Chil-

dren and Adults in Stamford.

The Scarsdale Junior League was enthusiastic over the proposed project, as many of its members had worked as Red Cross nurses' aides and as volunteers at the Army Air Forces rehabilitation hospital at Pawling during the war. They knew from that experience what disabled persons could do with training.

As a result of their efforts, and later those of the entire community, Mobility, Inc., received its first patient last April. He was a 3-year old boy who had bronchopneumonia at 4½ months, followed by meningitis. This had resulted in apparent deafness, blindness and hydrocephalus (enlarged head), and three head operations had been performed. When the child came to Mobility, he could see objects, respond to sharp and high-pitched sounds, and was learning to creep. After a month of therapy at the center and a home program carried out by the mother, the child had learned to crawl with reciprocal motion, was able to sit up and to stand with some assistance. He is continuing to make steady progress.

Among the forty patients who have come to Mobility since then, thirteen have been hemiplegics paralyzed on one side as a result of a stroke, and four have been amputees. One of the most complex cases has been that of a 19-year-old girl, whose long medical history included nephritis, concussion and

finally infantile paralysis. Paralyzed in the legs, the girl is now being trained to walk and travel with braces and crutches.

Although Mobility has a medical advisory board of top specialists who were appointed by the Westchester County Medical Society, it does not give medical treatment. Patients are received on reference from physicians or agencies, with full medical control of the patient retained by the referring physician. The center's staff physician, Dr. Eugene Moskowitz, who has had wide experience in both military and civilian rehabilitation, conducts the initial evaluation, determines admittance on the basis of feasibility of rehabilitation, prescribes the training program and periodically evaluates the patient's progress.

Special emphasis is placed on training patients to walk and travel, to care for their own needs and to perform other physical skills inherent in daily living. During the summer months, much of this retraining is done on the wide terraces that surround the cottage.

In addition to assisting therapists, volunteers from all parts of Westchester county have assumed the responsibility for the housekeeping, lunch room, library, receptionist and transportation services. Volunteers also make a motion picture record of the progress of each patient.

Organized as a non-profit corporation, Mobility, Inc., receives space, heat and light from the trustees of the Burke Foundation. Funds to cover operating expenses for the first year have been furnished by the New York State Association for Crippled Children and the Junior League of Scarsdale, with equipment purchased from gifts by individual citizens and service organizations.

PLEASE REMEMBER

Won't you please remember to patronize the advertisers whose ads appear in the Journal—They help to defray the costs of our publication.

ORTHOPEDIC BRACES FOR LOWER EXTREMITIES

by

CARL DAHMEN

Orthopedic Technician

The first modern orthopedic braces were developed and built by Professor Hessing. Such braces are molded leather, shaped over a plaster cast and reinforced with a steel frame.

Hessing leg and spinal braces are, if built correctly and effectively, anatomically and physiologically sound. However one must be aware of the fact that the construction of Hessing braces requires great patience and skill. These type of braces are very costly. The orthopedic braces as now in use by many hospitals are modifications of the principles developed by Professor Hessing.

Therapists and especially corrective Therapists often have to depend on proper and efficient functioning of a patient's orthopedic appliance to be able to conduct a rehabilitation program for the patient. In order to assist in the clarification of the use of the various appliances a certain standardization of technical terminology will be of help in prescribing the proper brace of appliance.

We will start with *drop foot* braces. There are generally three types:

1. The wire drop foot brace—a simple appliance made of hard steel wire attached to the heel of the shoe with a coil at the lower end and a calf band to secure brace to leg. The advantage of this brace is lightness and low cost. However this brace often breaks and it is best for the patient to have one in reserve.

2. The spring type (Klenzak) drop foot brace is a rigid ankle brace with the conventional stirrup and a steel spring imbedded at the ankle joint which can be adjusted with a screw-driver.

3. Rigid type drop foot ankle brace

with pin at ankle joint to keep foot at 90° ankle to floor. This type of brace is most often used for hemiplegia. A "T" strap is sometimes of aid to keep foot into proper posture to prevent eversion or inversion.

Ankle braces for fracture of the tibia and fibula are usually not sufficient unless the fracture is close to the ankle joint. Then an ankle brace with a long molded leather cuff from the ankle joint to below the patella is recommended. (Hessing type)

Most fractures of the lower extremities require a long leg brace with a knee lock. Long leg braces fall into two categories—

- 1—The supporting brace, 2—The weight bearing brace. The supporting brace is used in fractures where a good union has been established in the mid and upper part of the tibia and fibula. If the union is only partial in below knee fractures, or in most fractures of the femur, an ischial weight-bearing brace is recommended. The ischial weight bearing brace has to be fitted with great precision so the ischial ring really is weight bearing without creating too much discomfort to the patient.

In femur fractures near the head of the trochanter, a pelvic joint and band are essential.

For most fracture leg braces, calipers and tubing at the shoe are sufficient. Only with fractures close to the ankle the stirrup is essential, but in a non-union close to the ankle, no ankle joint of any kind is recommended. With no ankle joint a rigid shank in the shoe is necessary for support.

For paralysis of the lower limbs, paraplegia, polio, multiple sclerosis, no ischial weight-bearing is necessary.

These patients require a supporting

brace usually with stirrup, knee lock and knee cap. Consideration should be given to the amount of ambulation a patient is expected to do and the weight of the patient. For heavy patients a double knee lock (Schweitzer lock) is preferred. In normal cases a ring drop lock is sufficient.

So we have the following tabulation of braces for lower extremities:

1. Wire drop foot brace, 2. Stirrup type drop foot brace with spring at ankle (Klenzak drop foot brace), 3. Conventional stirrup type drop foot brace with rigid stop at 90°.

Leg braces: A—Long leg brace with stirrup at ankle, knee lock with or without pelvic belt.

B—Long leg brace with ischial weight-bearing with or without pelvic belt and calipers at ankle.

CALENDAR OF EVENTS

JULY 25 - AUGUST 12

Cerebral Palsy Workshop, Syracuse University, Syracuse, New York

AUGUST 20-22

House of Delegates, Board of Management, and Committee meetings of American Occupational Therapy Association, Hotel Book-Cadillac, Detroit, Michigan

AUGUST 23-25

Convention of American Occupational Therapy Association, Hotel Book-Cadillac, Detroit, Michigan

AUGUST 26-27

Institute of American Occupational Therapy Association, Hotel Book-Cadillac, Detroit, Michigan

SEPTEMBER 6-10

American Congress of Physical Medicine: twenty-seventh annual scientific and clinical session. Netheland Plaza Hotel, Cincinnati, Ohio.

SEPTEMBER 24-25

Meeting of the American College of Hospital Administrators; Cleveland, Ohio.

SEPTEMBER 26-29

American Hospital Association — 51st annual convention—Cleveland, Ohio.

NOVEMBER 7-9

National Society for Crippled Children and Adults—Commodore Hotel, N.Y.

Corrective Therapy Activities As An Important Ancillary In A Planned Treatment Program For Certain Neuropsychiatric Patients.

by

W. L. HARRIS, M.D.

V. A. Hospital, Northport, L. I., N. Y.

"Corrective Therapy in a Total Push Program for Neuropsychiatric Patients." First however, may I express the appreciation of Dr. Louis Verdel, Manager of the Veterans Administration Hospital at Northport, Long Island, New York, my own and of the Veterans Administration in general for the interest you have shown in asking me here today to tell you something of our work at Northport. Also, I should like to say that I have somewhat changed the title of my paper and as you hear me give it to you you may notice that it differs from the way it appears on your program. Please do not let the change of title confuse you, for although I have worded it differently for a specific reason, about which I will tell you later, there is actually very little difference between the two and the substance of what I shall have to say would be the same under either title. The title that I have given my paper is "Corrective Therapy Activities as an Important Ancillary in a Planned Treatment Program for Certain Neuropsychiatric Patients." With the foregoing explanation having been made, then, I shall proceed with my paper. In the October 1948 issue of the "Physical and Mental Rehabilitation Journal," the official

publication of your organization, I believe; there appeared an article I prepared at the request of your association president at that time, Mr. Sam Boruchov, dealing with and reporting upon the Reintegrative Service at the Northport Veterans Administration Hospital and its treatment program which had been established the previous December, just two months short of a year. In that article I dealt more or less with the over-all organization and activities of the Service, with however some emphasis on the part played by the Corrective Therapy Department in the treatment program, designed especially for the Service. I mention this now not because I intend merely reiterating here the contents of that article again, as such, today. I should hardly like to be accused of so deliberately trying to bore those of you who may have read it, though I may unintentionally do so anyway—but because it contains some rather pertinent facts upon which we might build or expand (and without being repetitious I believe) to better show the important role of corrective therapy as an integral part of a program, the aim of which is to bring about the rehabilitation of at least one category of mental patients.

Please do not interpret the latter statement as an inference on my part that corrective therapy is limited to this one category because that is not my intended meaning at all. I include the statement in the hope that it might serve in some way to point out that I am willing to speak more positively or even more dogmatically if that is better, when I have the occasion to express my opinion, as to the unlimited value of the Corrective Therapy Department activities, and the part these play in the over-all success we have had in treating this category of patients. I have no hesitancy in saying so because in that I have the backing of experience as my proof, and what more could be asked? Of the importance of C.T. in the treatment of other groups or types of patients, I have no doubt, but if one limits himself to that which he reasonably knows from experience, it is unlikely that anyone can justifiably question any statements made upon the subject.

In any event, it so happens the one category of patients about which I speak, includes probably the largest number of patients. They are the patients who, because they failed earlier to respond to the usual forms of specific therapy, are so much in need of the help we propose to give them. Should for some highly improbable reason, hardly imaginable, something force the limitation of C.T. activities even to this one category, C.T. activities would benefit the patients in this group to such an extent as to more than warrant their inclusion in any N.P. hospital therapeutic armamentarium. I am sure we need not fear such a limitation ever being forced on us.

Now I have quite clearly stated my proposition, i.e., C.T. has a definite and quite important role to play in an intensive treatment program designed to meet the needs of certain neuropsychiatric patients, and the primary aim of which is to bring about the rehabilitation of these patients, I believe I should at least attempt to show why I hold that opinion.

Published with permission of the Chief Medical Director, Department of Medicine and Surgery, Veterans Administration who assumes no responsibility for the opinions expressed or the conclusions drawn by the author.

First allow me to digress just one moment before I proceed. Such a program as I intend telling you about is frequently referred to as a "Total Push" program. Somehow, and it may be just a quirk of mind of my own, I have never liked the term, "Total Push". I for some reason seem always to associate the word "push" with the word shove. Then shoving seems to make me think of rush hours on New York subway trains, where there is always pushing and shoving aplenty. I have never liked being in on such pushing and shoving; therefore I do not like to liken our program at Northport to any such group behavior. There is of course no actual similarity between the two. It is nothing more than an unpleasant association of names in my own mind. I hardly think anyone would feel that such a title as "Total Shove" program would be very appropriate and although I know it will never be referred to as such, to me, "Total Push" reminds me so much of "Total Shove", I can never bring myself around to accepting or liking that name. Also, I am certain we never do such a thing as shove the patients around, or for that matter, if we must use the word push, push them around.

Perhaps it would have been better if I had planned my talk so as first to tell you about our particular efforts being carried out on the special treatment program at Northport, then later to give you the name by which we refer to it. I have preferred however, giving you the name first, it being the "Reintegrative Service", because the term reintegrative, I believe is meaningful and quite descriptive of what we are attempting to do for the patients with whom we work. Simply stated, we are trying to rehabilitate these patients by helping them to rebuild their personalities, split apart or disintegrated by the illness from which they suffer.

Knowing the name then, as you now do, should help you obtain a better mental picture of our over-all efforts as well as the integral part C.T. plays in that effort. I believe the name by which we now refer to it suggests, even without additional information, what it

is we might be attempting and I hope it will be clear to you when I have finished, why I am of the opinion it helps tell the story far better than the term "Total Push" does.

Now, then, to get on with the actual subject about which I wish to tell you. In order, however, that you may better understand why C.T. activities play such an important part in the program, it will first be necessary for me to describe for you a bit more in detail what we are attempting to accomplish on the Reintegrative Service at Northport by means of the planned treatment program we devised and now have been conducting for the past eighteen months. In order to give you this information in as concise a manner as possible, I have taken the liberty of including here the last paragraph or summarization of the article I wrote for your journal and to which I have already made reference. I do this because I believe I could not, in as few words at least, state it any clearer. I might also add, we have practically as our motto on the Service, the old copy-book adage, "Idleness is the devil's workshop." To read from my former article then, the one summarizing paragraph . . . "A new Service was established as an integral part of our hospital for the purpose of caring for and treating a definite category of patients. This definite but not too closely delineated group prognostically comes midway between those patients newly admitted to the hospital and under active intensive treatment and those patients under care on the continuous treatment service, the length of whose illness has rendered the possibility of their being rehabilitated as unlikely. The basic thought behind the actual construction of the treatment program herein presented, was that every effort be made to establish a treatment program as active and interesting to the patients as their illnesses would allow, and most important of all that it will always be time-consuming in such a manner as to adequately hold the patients constantly in contact with a reality situation by making every effort to keep them off the wards as much as possible during

each day. The accomplishment of the latter, it is felt, will prevent the all too commonly seen idleness of patients with nothing to do, observed on many hospital wards for beyond question, idleness is the surest road to regression and deterioration a patient can take in his constant flight and withdrawal into the oblivion of fantasy with its exclusion of reality."

Let me expand a bit on one or two statements just made, as I read the summary of my previous article. You will recall, if you followed me closely, I said, "A definite category of patients were to be and are being cared for on the newly established Service." I also said that the patients of our special group classify midway between the patients being cared for on the Admission Service, whose illnesses are of relatively recent origin, and who therefore have as a whole, a much better chance for making an adjustment than those patients, on our Continuous Treatment Service, whose illnesses have rendered the possibility of their being rehabilitated as unlikely.

Of course patients who fall into such a category have always made up a large proportion of the hospital population, but prior to the establishment of our program, it had always been impossible for many reasons which I shall not attempt to go into here, to separate them from the other two groups and give them a much needed special type of care.

That such a situation had been the case for so long was a rather disturbing thought to all of us and particularly to Dr. Verdel, who I told you is our hospital Manager or Director. You will note that I made the somewhat all-inclusive statement "all of us" and in this particular manner intended including myself. I had only joined the staff of the hospital at Northport a few days before Dr. Verdel and I discussed the matter, with the thought in mind of determining whether there might be some way of striking at the heart of the situation. Naturally, only having come to Northport a very short while before that, I could not possibly have been very familiar with the hospital

problems, etc., but when I had heard Dr. Verdel state what he had to say on the problem under discussion, I became more acutely aware that here is a problem, it would appear, which is by no means singular to Northport and certainly must be common to other large N. P. hospitals for evident reasons. Of those hospitals on whose staffs I had had the opportunity of serving and which fact in itself consequently had given me the chance to observe and note directly, I could recall similar situations existed in all of them. On still additional reflection, it occurred to me further that in all likelihood the same situation must exist in all our large N.P. hospitals. I had often thought about the matter to some extent before but had not fully formulated it in my mind.

Briefly, it was Dr. Verdel's opinion, after having spent many years as a staff member of this and many other hospitals, and now as Manager of this hospital where he is in a position to get a better over-all picture of the needs of

the patients than most of us possibly can, that there is a large number of patients not being rehabilitated who with some extra effort might very well be. Many unsurmountable problems in the past have been in the way of making this extra effort here and needless to say, would have prevented it elsewhere. But it was his opinion also, because many of the obstacles have been removed, we no longer can be excused for failing to make an effort to find out what we might do. Facilities, both non-professional and semi-professional personnel, as well as physicians (psychiatrists) were now available and the only thing that needed to be done was to work out some plan of attack on the problem.

Just in case I have failed to make it clear to you, as I should like to have you understand it, I will stop here for just a moment and perhaps somewhat by way of recapitulation, restate briefly the problem we felt should be attacked. Let me say here also that perhaps you have begun to think I shall continue

talking about everything but C.T. It may actually seem that I am approaching relationship of C.T. in a rather round-about way, but please hear me through and I believe you will understand why I have developed my theme in this manner. This is simply because only through a thorough understanding of the entire problem and our manner of approaching it could one possibly understand the part C.T. plays. Merely going through the process of enumerating what C.T. does in the program would mean little.

Its importance depends entirely on how well it can meet the needs of the patients and a full understanding of why it is imperative. Simply what is done and how to go through the routine of it without knowing why could never be enough. The importance of C.T. in turn depends still further on the fact that a full understanding of that need by the C.T. personnel permits them to choose correctly how best to fulfill that need and not just to go through

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SPECIAL ATTENTION TO THE DISABLED

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Editorial

The Psychological Impact Of Physical Disability

In accordance with the newer concepts of mental hygiene, those concerned with rehabilitation have been placing increasing emphasis during the past few years on the emotional and social problems faced by physically handicapped children and adults.

Although Medicine generally has come to recognize the importance of psychosocial services for physically handicapped children only within recent years, the emotional impact of disability upon the individual has commanded the attention of both research and clinical psychologists since the advent of modern psychology. Their theories have varied from the widely accepted concept of Alfred Adler, that disability serves as a motivating factor through compensation, to the more recent social psychological views of Roger G. Barker and others.

It is Mr. Barker and his colleagues' belief that the physically handicapped person, being a member of a minority group and subject to the same economic and social pressures as other minority groups, is likely to develop the same emotional outlook as those who are discriminated against because of age, sex, religion or race.

Most physically handicapped individuals, however, are not so much concerned with the social and psychological forces that produce the attitudes, values and concepts within themselves or the social group as with the question of how they as individuals can cope with them. As Lee Meyerson, University of Kansas psychologist, has written in the December, 1948, issue of THE JOURNAL OF SOCIAL ISSUES, the attitude of society toward the disabled has varied from the Greek view of "a sound mind in a sound body" and its negative implication of a crooked mind, crooked body, crooked personality, to the widely accepted overcompensation theories of Dr. Adler.

Meyerson also calls attention to the fact that in World War I, Americans were asked to believe that the withered arm of the Kaiser was responsible for the quest for power that led to war, and that during the last war, we repeatedly "explained" Goebbels in terms of his club foot, while at the same time we were "explaining" the greatness of Thomas A. Edison and Franklin D. Roosevelt in terms of Mr. Edison's deafness and President Roosevelt's infantile paralysis. Although such comparisons seem to be diametrically opposed, they can be reconciled if we remember that the behavior and attitudes of an individual, whether he be disabled or able-bodied, are determined by multiple factors.

Whether the physical disability serves as a stimulus either to social withdrawal or to aggressive behavior is dependent not only upon the disability but the complexity of other factors. For example, although it was expected that emotional disturbances would arise in practically every blinded soldier, clinical studies showed that those of the war blinded who were extremely stable individuals, reacted to the loss of eyesight with a surprising courage. Excerpts from some of their interviews read, "It makes you think a little, but I figure I'm lucky to be alive. They wiped out the rest of the men, a few got away. I was just one of the lucky ones. I've got to do my best now"; and "Well, being blind is just like being in the infantry, there's nothing you can do about it, it just happened. I think I will get along." Even a double-hand amputee who is also blind said, "I don't feel so badly

(Continued on Page 26)

LETTERS TO THE EDITOR

Editor:

This will acknowledge your letter of June 30, 1949, enclosing a copy of the June 1949 issue of the Journal of the Association for Physical and Mental Rehabilitation. The new format of this journal is particularly attractive, the articles comprehensive and interesting.

I would appreciate being placed on the mailing list for future issues of this publication.

Sincerely yours,

Paul B. Magnuson
Chief, Medical Director
Veteran's Administration
Washington, D. C.

Editor:

I have just seen the first copy of your Journal. I was very much impressed by the appearance and believe it is quite superior to those of previous years. There is no doubt you have excellent material to work with and it will require careful editing and selecting to present the most valuable material to the Association.

Give my regards to the fellows in your department.

Very truly

Edward D. Greenwood, M.D.
Director, The Southard School
Topeka, Kansas

Editor:

You have certainly done a wonderful job on the Journal. The format is exceptionally attractive, the articles cover the whole field, are well presented and have real quality. I don't know of anything which will do our Association as much good at this. Congratulations and more power to you. I received a letter from Dr. Flowers congratulating all concerned on the new Journal. It gives some recognition for real intelligent hard work.

Sincerely,

John Sisele Davis, Sc. D.
Chief, Corrective Therapy.
Veterans Administration
Washington 25, D.C.

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REHABILITATION OF THE CHRONIC MEDICALLY ILL

by

OTTO EISERT, M.D.

Chief Physical Medicine Rehabilitation Service

Manhattan Beach V. A. Hospital, Brooklyn, New York

Chronic medical patients, especially those in the older age groups, are frequently considered as custodial cases and left untreated for long periods of time. It has been thought that these people were incurable and therefore that treatment would involve time, personnel and expense which could be more usefully employed in acute and sub-acute cases.

Recent statistics show that since the beginning of the century the average life expectancy has increased from 49 years to 66.5 years. Morbidity and invalidism increases markedly after 50 years of age, and therefore it is obvious that the problem of caring for these people must be re-evaluated. Techniques aiming at rehabilitation should be used not only in the early phases of disease but emphasized equally when definitive treatment no longer is of great consequence.

In this study involving 128 chronic medically ill patients referred to the Physical Medicine Rehabilitation Service in the Manhattan Beach Veterans Administration Hospital in 1947 we

believe that it has been clearly shown that results can be obtained to some degree no matter how great the disability, no matter how poor the prognosis and regardless of age.

In the Manhattan Beach V. A. Hospital the Physical Medicine Rehabilitation Service is set up along the lines approved by the Veterans Administration. It consists of five essential units;—Physical Therapy, Occupational Therapy, Corrective Therapy, Educational Therapy, and Manual Arts Therapy; thus the patient can be guided from the actual treatment of his initial disability to instruction in self care, ordinary and special locomotion, such as climbing and descending stairs and curbs. Educational Therapy stresses special speech classes for aphasics, reading and writing as well as other academic and commercial subjects, the latter emphasizing socialization and adjustment to possible reemployment. In Manual Arts Therapy, shop subjects are prescribed for the same purpose. The entire program is continuous and integrated so that the patient's interest in the regimen

is maintained. In addition, a Rehabilitation Board is convened frequently for the consideration of these severely disabled cases. This Board consists of the physiatrist, who is the chairman, and representatives of the various units of the Physical Medicine Rehabilitation Service who are assigned to the patient, the ward physician who referred the case, the psychiatrist, the social worker, and a vocational guidance adviser. The social worker is an important member of the Rehabilitation team, laying the groundwork for the patient's final readjustment to his home, family and job.

PROJECT A

128 unselected medical patients, who had been referred en masse to the Physical Medicine Rehabilitation Service following transfers from other hospitals where they had been for periods of a few months to ten years, were used as a basis for this study. Their average age was 55 years. These patients were treated individually and studied intensively. The original period chosen for this study was from January 1, 1947 to January 1, 1948.

A battery of 100 tests which included simple tasks inherent in daily living was used in order to obtain the percentage of self care attained.

In Table I the percentage of self care attained considering the total number of patients treated is indicated. It is shown that 116 or 90.9% of the patients were benefited, and as can be noted in the chart only 3 of these patients attained less than 50% self care. It is to be noted that by 0% we mean complete disablement with no amount of self care, whereas at 100% the patient is able to perform all the necessary function of ordinary daily living. 74, or 64%, of this group were discharged from the hospital. In the year following the period of the original study 20 more patients have been discharged. Only one patient was readmitted. This patient was not readmitted primarily for his original physical disability, which was multiple hemiplegia.

Reprinted from the Archives of Physical Medicine, July 1, 1949

TABLE I—49 patients went from 0% self care to 100% self care

13 patients went from 0% self care to 75% self care
18 patients went from 0% self care to 50% self care
3 patients went from 0% self care to 25% self care
1 patient went from 25% self care to 100% self care
5 patients went from 50% self care to 100% self care
19 patients went from 75% self care to 100% self care
5 patients went from 25% self care to 50% self care
3 patients went from 50% self care to 75% self care

—
116 patients (74, or 64%, were discharged from hospital)

In the following tables 2 to 9 an attempt is made to consider the amount of improvement attained in relation to particular diseases.

In Table 2 a group of 28 patients suffering from Rheumatoid Arthritis is considered. Out of this group 23 attained 50% or more self care. One patient derived only 25% improvement, which however enabled him to care for himself with a minimum amount of special attendant assistance. 4 patients did not derive any benefits. The average length of treatment time for maximum benefit was 3 months.

TABLE 2—ARTHRITIS

1 patient went from 0% self care to 50% self care
1 patient went from 0% self care to 25% self care
2 patients went from 25% self care to 50% self care
2 patients went from 50% self care to 75% self care
1 patient went from 50% self care to 100% self care
17 patients went from 75% self care to 100% self care
4 patients did not derive any benefits from Physical Medicine
— Rehabilitation Service
28 patients

In Table 3 ten patients with Multiple Sclerosis are considered. Seven of these patients attained 50% or more self care, one patient went from 0% to 75% self care, and only two patients did not derive any benefits. The average length of treatment time for maximum benefit was 4.5 months.

TABLE 3—MULTIPLE SCLEROSIS

1 patient went from 0% self care to 25% self care
2 patients went from 0% self care to 50% self care
1 patient went from 0% self care to 75% self care
1 patient went from 50% self care to 75% self care
3 patients went from 50% self care to 100% self care
3 patients went from 50% self care to 100% self care
2 patients did not derive any benefits

—
13 patients

In Table 4 it is indicated that nine patients with Parkinson's disease are considered. Three of these patients went from 0% to 75% self care, four went from 0% to 50% self care, and two patients derived no benefit. The average length of treatment time for maximum benefit was 5 months.

(Continued on page 17)

CORRECTIVE THERAPY

(Continued from page 13)

some useless routine. The latter might possibly be sufficient for some other type of patients but certainly it would offer no help to this particular type of neuropsychiatric patient so much in need of help with whom we are dealing.

Let me take a moment, then to as briefly as possible review for you what I refer to as the problem concerned, or again, what it was we planned to do and are now attempting to do on our planned treatment program. As I told you before, it was decided that a large number of patients who in the past had become life-long hospital custodial cases, might be prevented from becoming such if some special attention could be given to them. It seemed reasonable to believe from long observation, that in spite of the fact many of our patients fail to respond to the usual standard established forms of therapy given them during their early hospitalization (on the Intensive Treatment Service) such as the shock therapies, that is for example insulin and electric shock many of them still have, from all clinical evidence, relatively good prognostic outlooks. This opinion was formulated on the basis of a long since established fact which follows: An appreciable large percentage of patients admitted to the hospital suffering with schizophrenia actually do not regress beyond the point where contact cannot be made with them for a far longer time than many seem apparent on the usual observation. Also what may well seem to be a state of deterioration in many of them is far more likely to be that of regression only and this regression does not become a deteriorative process actually for several years. Those two facts therefore seem to be sufficient justification for assuming that any intensified efforts that might be carried out for saving at least some of these cases from inevitable chronic deterioration with its life-long need for hospital care would be unquestionably worth far more in success than any additional expense incurred in carrying out such a plan.

Most of the patients in question, it

(Continued on next page)

(Continued from preceding page)

TABLE 4—PARKINSON'S DISEASE

4 patients went from 0% self care to 50% self care
3 patients went from 0% self care to 75% self care
2 patients did not derive any benefit
—
9 patients

Table 5 deals with thirty-two hemiplegic patients, practically all of whom also suffered from severe arterial hypertension and cardiac disease. The age varied from 55 to 65 years. The average length of treatment time for maximum benefit was 4 months.

TABLE 5—HEMIPLEGICS

11 patients went from 0% self care to 100% self care
4 patients went from 0% self care to 75% self care
7 patients went from 0% self care to 50% self care
1 patient went from 0% self care to 25% self care
1 patient went from 25% self care to 100% self care
3 patients went from 25% self care to 50% self care
1 patient went from 75% self care to 100% self care
2 patients went from 75% self care to 100% self care
—
32 patients
2 patients did not derive any benefits

In Table 6 three paraplegics are considered; one attaining 100% self care, another 50%, and the third showed no improvement. The average length of treatment time for maximum benefit was 8 months.

TABLE 6—PARAPLEGICS

1 patient went from 0% self care to 100% self care (Neurofibromatosis)
1 patient went from 0% self care to 50% self care (Transverse Myelitis)
1 patient did not derive any benefit
—
3 patients

In Table 7 two patients are considered who had severe Buerger's disease which had hospitalized them for two years. One attained 100% and the other 75% self care. The average length of treatment time for maximum benefit was 3 months.

TABLE 7—BUERGER'S DISEASE

1 patient went from 0% self care to 100% self care (single amputee)
1 patient went from 0% self care to 75% self care (single amputee)

In Table 8 there are two patients diagnosed as having Peripheral Arterio Sclerosis Obliterans of the lower extremities who attained 100% self care. The average length of treatment time for maximum benefit was 1.5 months.

In Table 9 there was 42 remaining patients (all medical invalids) consisting mainly of cardiacs, asthmatics, patients with diabetic gangrene, syphilitic disease of the central nervous system, cirrhosis of the liver, muscular dystrophies and atrophies, etc. Of this group 34 patients went from 0% to 100% self care, 4 went from 0% to 75% self care, 3 from 0% to 50% self care, and 1 patient did not derive any benefits. The average length of treatment time for maximum benefit was 3 months.

(Continued on next page)

CORRECTIVE THERAPY

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was found, were scattered throughout the other Services of the hospital, wherever bed accommodations were found for them as they came from the Acute Intensive Service. As would follow from the foregoing, they were being cared for along with many patients whose illnesses were of such duration that less response to any regime could be expected. Therefore physicians in charge of the various wards of the hospital where they were being housed found it necessary to do the best under the circumstances for these more prognostically hopeful cases, while at the same time rendering attention to their already heavy case load of patients in need of an entirely different kind of attention. I believe I mentioned before that such a situation has always been previously made unavoidable by the large number of patients it is always imperative a hospital of the size of ours and other large N.P. hospitals receive. That then is more or less a brief statement or review of the problem we felt we should set out to attack.

Entirely due to the foresight and courage of Dr. Verdel, we prepared to initiate a new Service. The new Service began then with a plan of treatment built more or less simply on the assumption that through a concentration of these relatively more hopeful cases into one group and by careful planning and timing, making maximum use of the splendid already available hospital facilities, we could best accomplish our task.

Detail of the uses of the facilities of the several special departments that were to be taken advantage of in making up the program planned for the Service will of course not be included here, nor will the activities of the personnel of these departments be listed. Exception to this will be made in the case of the C.T. department . . . it being the purpose of my paper of course to give you that information.

In passing on however, it might be well to say that it was through making maximum use of all the special depart-

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TABLE 9—34 patients went from 0% self care to 100% self care
 4 patients went from 0% self care to 75% self care
 3 patients went from 0% self care to 50% self care
 1 patient did not derive any benefit

42 patients

There was a small group of 12 patients who did not derive any benefit from the program and these may be considered our true failures. It is important to emphasize that there is bound to be a certain amount of failure, 9.1%, in our series because of poor prognosis in practically all of the cases, as noted in Table 10.

TABLE 10—0% SELF CARE TO 0%
 SELF CARE—12 PATIENTS

Parkinson's disease	2 patients	same age bracket with similar disabilities who did not receive the benefit of the Physical Medicine Rehabilitation program were compared. The control group was selected from other hospital records. The average length of hospitalization of patients not treated by this Service was 6 years and as a matter of fact are still being treated, whereas the average length of time of the same types of cases treated in this Service was 8.43 months.
Muscular dystrophy	1 "	
Arthritis	4 "	
Multiple Sclerosis	2 "	
Paraplegia	1 "	
Hemiplegia	2 "	
	12 patients	

A group of seven hemiplegic patients who were treated in our service and another group of patients within the

TABLE II — PERIODS OF HOSPITALIZATION

Patient	Entered P.M.R.S.	Discharged	CONTROL GROUP		
			Patient	Entered a V.A. Hosp.	Present
A	1-1-47	1-1-48	H	1936	X
B	6-26-46	6-19-47	I	1946	X
C	12-1-46	6-2-47	J	1938	X
D	2-1-47	8-25-47	K	1945	X
E	6-26-46	9-10-47	L	1942	X
G	8-11-46	1-19-47	M	1941	X
			N	1946	X

PROJECT C

In this project a comparison was made of the time of hospitalization of a group of hemiplegic patients before and after treatment in the Physical

Medicine Rehabilitation Service. Table 12 illustrates that the hospital stay was shortened considerably upon entering the program.

(Continued on next page)

CORRECTIVE THERAPY

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ments and what they had to offer our patients on a therapeutic level, that we were able to devise a timeconsuming though interesting program that we felt would fill the needs of the particular patients in question.

Also, before going more into detail about the specific part C.T. was given in our program—and I can parenthesize here a bit by adding, now that 18 months have passed since the program was first put into operation, that C.T. has admirably fulfilled that role in an invaluable manner and we know now C.T. efforts to have been indispensable—it seems pertinent I ask you to recall I told you earlier that we have what amounts to virtually a motto in the copy-book adage—"Idleness is the devil's workshop". I bring this in again, irrelevant as it may seem to you, because it is with that in mind that much care was used in the proper building up of a daily schedule for the patients on the Service.

I should like not to have to go into the matter of symptomatology here but because—and I think I am correct in assuming that all of you present here today do not perform your duties with mental patients—it will be necessary if I am to make myself wholly clear on this subject to tell you one or two things about mental patients. One thing that will simplify this is that almost without exception we only care for schizophrenics on our Service.

In a way probably that will of course make it easier for me to get across to you in an understandable manner, just why the matter of symptomatology in mental illness has such a relatively important bearing on our subject in general. Schizophrenics have notoriously one symptom invariably common to them all. Telling you what this is should, you might think, be all that was necessary. But unfortunately the one symptom is our Jonah and because of it virtually our entire problem is created. In other words, it is because of this one outstanding feature I am here today talking to you as I am about

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TABLE 12

Patient	Entered V.A. Hosp.	Entered Phys. Med. Rehab. Program, Manhattan Beach	Period of Hospital- ization before entering Program		Discharged from Manhattan Beach V. A.	Time in Program
		V.A. Hospital				
O	3-13-38	1-10-47	8 yrs.	9 mos.	6-4-47	5 mos.
P	12-19-38	2-15-47	8 yrs.	2 mos.	3-21-47	1 mo.
Q	3-1-45	1-16-47	1 yr.	10 mos.	4-1-47	3 mos.
R	3-15-45	1-8-47	1 yr.	9 mos.	1-23-47	15 da.
S	10-21-41	1-8-47	5 yrs.	2 mos.	5-21-47	4 mos.
T	10-30-45	3-7-47	1 yr.	5 mos.	9-3-47	6 mos.
U	5-27-46	7-2-47	1 yr.	1 mo.	9-11-47	2 mos.
V	7-5-45	3-3-47	1 yr.	8 mos.	9-12-47	6 mos.
W	7-25-47	8-2-47	8 days		10-8-47	2 mos.
X	2-19-47	7-28-47	5½ mos.		10-24-47	3 mos.

COMMENT: From the above study it can be seen that over 90% of the chronic medical patients can be rehabilitated at least to the extent that the amount of attendant and nursing care necessary is greatly reduced and ultimately to the point where most of them can go home. In this series 64% of the group were discharged from the hospital. In the past the respective families were frequently informed that the prognosis was hopeless and that the patients had become more or less custodial problems. Little or no treatment was instituted. This led to increasing apathy, loss of morale and the will to improve on the part of the patients. Frequently their limbs became fixed in useless positions and bed sores developed. With the aid of the Physical Medicine Rehabilitation program this situation was changed to such an extent that the wards became cheerful, the patients became more interested in life, and the morale of the medical staff soared. The family was invariably delighted at the patient's improvement and subsequent discharge from the hospital.

In this connection it is believed that in addition to the Physical Medicine Rehabilitation program for in-patients, a good out-patient program is necessary to provide for the continuity of treatment following discharge. Thus many patients who in the past had to remain in the hospital would be enabled to go home much earlier. Transportation facilities should be provided to facilitate treatment in the Out-Patient Department.

Common sense, ingenuity, and perseverance are very necessary in the treatment of these cases. The physician in charge must at all times maintain the attitude of optimism which will in turn be communicated to the patients. Each case presents different problems. In one case a patient with bilateral cerebral thrombosis, who had been bed-ridden for many years, received the necessary amount of muscle reeducation and strengthening but was unable to stand because of a marked tendency to fall backwards. This was remedied by increasing the height of his heels so that the center of gravity was shifted forward. Later when the patient developed good equilibrium and muscular control the heels were lowered gradually until they were at the normal height.

A trained group of therapists working under the direction of the physiatrist is extremely essential. There must be close collaboration between the various members of the group. Each patient must be treated individually. It is the details in the diagnosis, the details in medical and surgical care, and the details involved in the Physical Medicine Rehabilitation process which are essential to produce the best ultimate results. Finally, it is felt that rehabilitation of chronic patients should be undertaken without considering the previous length of their hospitalization or ultimate prognosis associated with the disease.

SUMMARY: 1. Rehabilitation is of primary benefit to chronic medically ill patients, as is indicated by the improve-

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a problem of concern to us all through mutual interest in attempting to do what we can to prevent its ravages.

Those of you who have ever worked or are now working with N.P. patients will bear me out no doubt, when I tell you what this one invariably present symptom is and then later attempt to describe for you this one characteristic feature all schizophrenics display in their behavior. There are of course many other outstanding features common to all types of schizophrenics, but hardly one of them is so invariably present. Actually though it may be going a bit outside my subject to bring the matter up, it is important and I will only mention it briefly in passing. In my opinion, all the many commonly enumerated symptoms which characterize Schizophrenics spring from or grow out of the one difficulty I have been mentioning. What then is this all important characteristic of schizophrenics? Stated as concisely as I am able to give it to you, I shall put it this way.

All schizophrenics, whatever may be the final answer as to the cause of this illness, have a characteristic rejection of the reality world about them and prefer to, or at least do, create for themselves a substitute phantasy world in its place. This substitution of a phantasy world for the real, varies in degree anywhere from partial substitution to complete rejection of the real. The degree of difficulty in working with them, ie., making a contact with them at an adequate level, is therefore directly proportionate usually to the degree each one of them has substituted their own fantasy world for the real and also how thoroughly each may have burned the bridge behind him. (Speaking figuratively of course). Fortunately for those of us who are attempting to work with them, experience has taught us that the matter of bridge burning by the majority of them is at first not a too thoroughly done job. It gives us an inroad over which many of them can to a large extent be brought back and if some care is used, held back in

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ment of 90.9% of the patients and the discharge of 74, or 64% of this group.

2. There is less nursing and attendant care required.

3. The patient can expect to take care of himself.

4. The family in turn feels that the patient is not necessarily a hopeless invalid and welcome his return.

the real world, even though there may be some psychic scarring as evidence of their excursion into the other world of phantasy. I hope you will not have minded too much the figurative way I have just put it and have not become confused by the abstraction.

The foregoing description I have just given you, brings again to mind something of what I had already told you earlier in my paper. If you will recall, you will remember I told you while I was explaining the manner in which we came to a decision on the need for a planned treatment program, we felt would offer much to many patients falling into a so-called in-between category. I told you it was because experience had shown us many patients do not deteriorate for quite a few years to an inaccessible degree. I also mentioned that their condition then was one of regression, which is frequently reversible, until deterioration has taken place. At that time I was actually saying in somewhat a less figurative way, the same thing I have just tried to define to you more by way of analogy.

This pretty well brings us down then to the actual meat of our discussion. We have reached that point by a somewhat circumlocutious route (to use a 64 dollar word) you may be thinking. Too, there actually is little more to be said. The remaining few words would however, convey much less useful information to you if I had not made the effort up to this point to tell you all I have. Because the following, I venture to say, will seem to take on more meaning to you if you will attempt to keep in mind the preliminaries I have given you first.

Our aim has been, as I brought out when I read from my former paper, to make every effort to establish a

treatment program as active and interesting to the patients as their illnesses would allow and most important that it be time-consuming in such a manner as to adequately hold the patients constantly in contact with a reality situation, thereby not permitting long periods of idleness, (our so-called Devil's Workshop), to offer them the lure of the phantasy world to which they are so easily and readily drawn. In trying to accomplish that has it posed a problem? I can say with emphasis . . . YES! Had we a medical staff even several times over the number we now have (and the number we now have already greatly taxes the available supply of physicians trained in psychiatry), considerable help from other sources would even then still be needed.

It is not difficult for you to imagine thae even giving each patient all the time he need spend with a physician, individually or as one of small groups, time would lie heavy on the patient's hands between the sessions with the physicians. This is particularly true in an N.P. hospital, where factors beyond our control make confinement of some type or another for the patient, absolutely imperative as a safety factor.

Would not our very aim be an impossibility to accomplish if we could not call upon other suitably trained people to help us accomplish what we are striving for? It is here then that we look about us for these helpers and behold, there is C.T. like the magician with much up its sleeve to help us. "Where have you been all these years, we say," "Oh!" is the reply, "We've been around for a long while as the voice in the wilderness. We finally grew in numbers sufficiently to make ourselves heard. We have however, only recently been made manifest so you could see us. Can we be of help," "Can you?," we say. "You may already consider yourselves incorporated well within our program. And here it is. (at this point copies of the program will be held up and passed out). You will be delegated to give vigorous reconditioning exercises; medicine ball and apparatus exercises; remedial exercises and postural exercises where

prescribed. The foregoing will be given in one particular gymnasium best suited for this and in turn each group of patients will be taken through the various exercises described. In a differently located gymnasium, such informal activities as will from time to time be arranged by the Corrective Therapy Chief and the Ward Physician, will be carried out. Here also use of the punching bags (both light and heavy) will be encouraged in an effort to relieve some of the aggressive tendencies and tensions displayed by many of the patients as characteristic of their illness. Ping pong and miniature bowling will be played to encourage the spirit of competition. There will be numerous forms of wall apparatus for those not able to enter into competitive activities; also passive games and habit training. At still a third location, resocialization activities, under the direction of the Corrective Therapy Section with the Gray Ladies of the American Red Cross as assistants, will be given. Here also, habit training along the lines necessary for participation in the resocialization functions will be promoted. As weather permits, outdoor activities with the instructors will be held and the fundamentals of different games of sport will be given and at other times, hikes about the reservation with appropriate instructions as to locale and its geography. Any of the activities mentioned so far will be both supplemented by and replaced as the occasion may warrant, ie., howling in the regular bowling alleys and swimming in the hospital swimming pool. I hope you will take no offense at the manner in which I have tried to bring into final view the importance of C.T. as a part of our program and as one of our top value therapeutic adjuncts. Through its offering, great contributions have been made toward the success we have already had.

But I'll stop here and not burden you with any report on how many patients we have already been able to send out of the hospital or how many more are approaching that goal. Should however, this interest you, let me know and I will give you that information. May I thank you for your indulgence in hearing me through.

REVIEWS

MEDICINE ON THE MARCH. By Marguerite Clark, 308 pages, New York: Funk & Wagnalls Co., \$3.50.

By David Ser

The purpose of this book is to give its readers the latest medical development already authenticated by experts, in one convenient volume; so as to be able to understand the whole dramatic picture of medical progress. The book is based largely on medical journal reports and papers read at medical conferences personal visits to hospitals and research laboratories. The book can serve the doctor and the intelligent laymen with important medical information without the bother of hundreds of hours of intensive reading. The reports in the book have reliable information covering high blood pressure, heart disease, infantile paralysis, tuberculosis, mother and child health, cancer, alcoholism, epilepsy, rehabilitation, and war medicine.

Of special interest to rehabilitation workers and therapists is the chapter on Psychiatry, Rehabilitation & War Medicine. The old familiar slogan is again used which is the guiding hand of Rehabilitation. "The handicapped person works; he is not worked on." We can get muscles to perform far greater tasks than originally thought. When injury strikes, muscles respond with self-repair, adaptation or adjustment to new conditions, over development and enlargement and substitution.

MEDICINE ONE THE MARCH is the record of these advances as they have been reported in authoritative medical literature, government reports, papers read at medical meetings by top-flight medical researchers and clinicians. These reports, which include news of the latest research, treatments, surgical techniques and drugs, have now been synthesized in one volume—a highly vital and useful compendium for both individuals and groups interested in their own and in the public's health.

Gymnastique Medicinale
Et Chuŕyicole Clement-Joseph Tissot
(1870) Paris, from *Occupational Therapy and Rehabilitation Magazine*.

April 1949—Volume 28 No. 2

This is an outstanding article on Medical Gymnastics written in 1870 by Clement-Joseph Tissot. Tissot's contributions to Corrective Gymnastics were so advanced that for a century and a half following his contribution, writers merely mentioned his name in passing. Tissot was the first to recommend and prescribe activities as therapeutic exercises.

The article concerns itself first with the convalescent care following hospitalization. Tissot mentions important results of prolonged bed-rest which are characteristic of modern thinking, for instance, constant bed-rest may bring on many changes, such as malaise, malaise, weakness, swelling of the arms and especially of the legs. In short, the body has lost the ease and promptness of its natural functions. Tissot emphasizes mobilization in the convalescent period but believes that the regime should be accomplished gradually. The indication for motion is very apparent but the patient is so weak and thin from being bedridden for a length of time that dizziness may occur. However such a reaction may be avoided by first having the patient sit on the edge of the bed with his feet dangling and then gradually reach the stage of walking.

Secondly: Tissot concerns himself in the article with stiffness and contractions of joints which are the most common forerunners of ankylosis, are usually caused by shortening of the ligaments and tendons of the muscles which draw the limbs back and hold them shortened, as is seen after the treatment of fractures, luxation, gout, paralysis. Treatment concerns itself with an anticipation of loss of muscle, and ligament elasticity and to prevent

the thickening of the synovia while still possible.

The recommendations of Tissot are as useful today as when they were first written and are a contribution to the field of Therapeutic Exercise.

Lou Braun

THE IMPORTANCE OF STABILIZATION

By Charles LeRoy Lowman, M. D.

Abstracted from the Physical Therapy Review, June 49, Vol. 29, No. 6.
Pages 253-255.

The author studies the effect of paralysis of stabilizing muscles in the early convalescent phase of poliomyelitis. Frequently, the function of deficiency of the limb is not due to the paralysis of the intrinsic muscles of this limb, but to weakness of a muscle which stabilizes the base. Examples of such cases are impairment of shoulder abduction due to rhomboid and trapezius palsy, poor hip flexion produced by weak abdominals which allows forward tilting of the pelvis, the gluteus medius limp, and the limp which is caused by unilateral absence of the quadratus lumborum and obliques. Failure to recognize the importance of the trunk stabilizers in these disabilities often leads to long continued intrinsic exercises without results.

For the prevention of deformities, it is just as important to recognize weakness of stabilizing muscles as well as to be aware of the imbalance of intrinsic muscles. The author shows in several examples how lack of fixation leads to deformities. Therapists should also pay attention not to exercise their patients in asymmetrical positions and they should avoid to keep patients with trunk and leg involvement in a sitting position for long periods. The effort of keeping balance without competent stabilizing muscles may exert a deforming influence.

Paralysis of the trunk and abdominal muscles has an influence on the cardio-respiratory functions since the thoracic cage must be well stabilized to give the diaphragm a base of action and the abdominals are necessary to help in the expiratory effort.

The effect of the impairment of sta-

bilizing muscles can be treated surgically by fascial transplants which will immobilize the base structure. The author relates good results with this technique and shows examples of stabilization of the scapula, of the pelvis, and of the femur. Proper exercises, corsets, and braces may also be used for stabilization.

Gerald Hirschberg, M. D.

Progressive Resistance Exercises in Cup Arthroplasties of the Hip, by Thomas L. DeLorme, M. D. and Arthur L. Watkins, M. D., from Archives of Physical Medicine, June 1949. Vol. 30, No. 6.

Dr. Thomas L. Delorme, M. D., a Baruch Fellow in Physical Medicine, at the Harvard Medical School and Dr. Arthur L. Watkins, Associate in Medicine, Harvard Medical School, both discuss the rehabilitation of the cup arthroplasty patient. They divide the rehabilitation of the cup arthroplasty patient into three phases: (1) the first four postoperative weeks; (2) the ambulatory hospital period which starts when the patient first becomes ambulatory and extends until he is discharged. (3) the convalescent or final phase, which starts at the end of the eighth week and continues until maximum function has been obtained.

Various methods and techniques for exercising each hip muscle have been presented. Proper individual case analysis and therapeutic exercise equipment, optimum exercise equipment optimum exercise routines for restoring joint motion and muscle power are possible even in the most complicated mechanical situations.

The authors present an adaptation of DeLorme's exercise program to cup arthroplasties.

Progressive resistance exercises are useful in restoring hip muscle strength in these patients. They are usually started at the end of the third month but may start earlier with minimal resistance and counter-balancing. Except where hindered by pain, lack of cooperation or firmly rooted habit patterns, muscle strength substantially improved in one to three months of exercise.

CHILDREN WITH MENTAL AND PHYSICAL HANDICAPS

By J. E. Wallace Wallin, Upsala College

THIS forthcoming book discusses the educational, psychological, social, eugenic and medical problems of the handicapped. Scientific, up-to-date and comprehensive, it contains much material not found in medical texts, and material they touch on only briefly. Ideally suited as a basic text for classes in Psychology of Handicapped Children, Mentally Deviating Children and Exceptional Children.

Published 1949 (Sept.)

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6" x 9"

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HERE is a broad study of physical defects and the recreational sports available for those afflicted. Features of the second edition include: new information on war-incurred disabilities; elaboration of principles and methods of therapy currently used in Veterans' Administration and civilian hospitals; 38 action pictures showing disabled persons participating in typical sports.

Published 1947

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REHABILITATION IN THE NEW YORK CITY HOSPITALS

By

HERBERT SCHEFFER, M.D.

Acting Director, Bureau of Medicine
and Hospitals, N. Y. C., N. Y.

Rehabilitation has always been an established practice in the New York City institutions but it has been known under many guises and by a variety of designations. Among these have been moral treatment, work cure, reconstruction work, physical education, training, reconditioning and rehabilitation.

The annual report of the Board of Alderman from the Asylum on Blackwell's Island for the year 1848 states—"There have been discharged, recovered, 194." "Much dependence has been placed upon moral treatment and this favorable result has been produced principally by employing patients in manual labor."

The report of Bellevue Hospital for the same year contains this quotation.—75% of the whole number of patients were discharged cured, or so relieved as to provide for themselves." "For many of the patients suffering under surgical or chronic diseases, employment is salutary when not carried to the point of fatigue."

The annual report of 1858 from the Blackwell's Island Asylum reads as follows:—"Discharged and returned to their homes, 193." "Female patients—articles such as embroidery, pencil drawings, fancy work, etc., have been exposed for sale. Male patients—introduction of military drills, one each day, with fife and drum corps made up of their own members. any cases of delirium tremens are sent to this place. After recovery if they were kept at hard labor a few weeks, the effect would be salutary in reclaiming them."

Rehabilitation more closely approximating the modern version was intro-

duced into the municipal hospitals in 1918-19 following World War I and has continued without interruption to the present. Occupational therapy, physiotherapy and social service worked independently of each other although in some instances informal consultations were held between members of the medical staff social workers.

There was direct referral in many instances from one to the other and to the State Department of Vocational Education. Between 1930 and 1940, dressmaking, photography and other pre-vocational activities were initiated and developed.

In 1938 and 1939 at Kings County Hospital, under Dr. Tenopyr's direction and active interest, many patients were taught to walk and to go up and down stairs.

In January 1938 the Medical Board at the Municipal Sanatorium expressed the need for a rehabilitation program at that institution. A preliminary survey conducted at that time revealed the need for a program of vocational rehabilitation. In September 1940 a co-operative agreement was entered into by the New York City (New York, Brooklyn and Queens Tuberculosis and Health Associations) to make a three year study "for the purpose of investigation and determining needs of persons handicapped by pulmonary tuberculosis and to determine and establish methods of (a) vocational guidance and advice; (b) selection of cases for preparation for employment; (c) placement in employment of such handicapped persons." In 1941 a Rehabilitation

(Continued on next page)

WE INTRODUCE

HOWARD A. RUSK, M. D. — — —



University of Pennsylvania graduate and former instructor in Medicine at Washington University, St. Louis. Dr. Rusk left his medical practice in St. Louis to join the Armed Services as Chief, Convalescent

Training Program, U.S. Air Force. There he established an outstanding rehabilitation program which became standard in all AAF hospitals and later was adopted by both Army and Navy. In September 1946, Dr. Rusk was made Professor of Rehabilitation and Medicine at New York University Medical College, the first chair of this kind in any university. He is also a member of the advisory board of the Association for Physical and Mental Rehabilitation. In addition to his other duties, he conducts a weekly medical column in the Sunday New York Times.

EVERETT M. SANDERS



He brings to the field of Corrective Therapy an experience of forty years in the field of Health and Physical Education. Most of this time he has been in Indiana Pennsylvania State Teachers College.

He was Lecturer at the University of Pittsburgh in Massage and Corrective Physical Education. At the Harvard Summer School of Physical Education in Swedish Gymnastics, Massage and Applied Anatomy. Graduated from the Pose Normal School of Gymnastics as a Medical Gymnast; the University of Pittsburgh with B.S. degree in Ed.; T.C. Columbia, M.A. in Health Education.

He is now completing an article on "Mobilization of Paraplegics" which has been accepted by Dr. Frank Krusen for the Year Book of Physical Medicine.

REHABILITATION

(Continued from page 23)

Director was appointed to carry on the program. The Rehabilitation service was established at the institution in 1943. A report of this activity under the title of — "The Rehabilitation Program at The Municipal Sanatorium, Otisville, New York" was published by Dr. I. D. Bobrowitz and Mr. Joseph Newman in 1946.

During World War II, In-service training courses were given to occupational therapists in the use of graded activities as treatment for traumatic cases and 97 "Waves" from the United States Navy received clinical training in this use of occupational therapy.

In 1944, a Division of Physical Medicine was established at Bellevue Hospital under the auspices of the New York University College of Medicine, with the aid of a grant from the Baruch Foundation.

In 1946 a more comprehensive program of Medical Rehabilitation was undertaken in Bellevue Hospital under the supervision of the Department of Rehabilitation and Physical Medicine of the New York University College of Medicine

At the present time, active rehabilitation programs are being conducted at Bellevue, Kings County, City and Metropolitan Hospitals. A program under the direction of Dr. Rusk has been organized at the Goldwater Memorial Hospital.

Bellevue Psychiatric and Kings County Psychiatric Hospitals have well developed physio therapy, occupational therapy and recreational programs and a diversional and occupational therapy program is in operation at the New York City Cancer Institute.

An active program of occupational therapy and recreation is provided at the New York City Home for Dependents and at Farm Colony, both of which are large custodial institutions of the Department of Hospitals.

The estimate of the Hospital Council of Greater New York that 5% of the general surgical patients, 15% of the medical patients and 85% of the orthopedic cases need rehabilitation and re-training in order to go back to work

is illuminating.

The demonstrated effectiveness of the comprehensive rehabilitation program in operation at Bellevue Hospital has been the inspiration for the general adoption of a like coordinated effort in all of our hospitals and institutions.

There, psychiatric consultation service is provided upon request. Treatment is conducted at the bedside or in the facilities of the department. Selected cases are transferred to the rehabilitation wards.

All of the resources of the hospital are brought to bear upon the solution of the problem presented by each case on an individual basis.

Liaison is established and maintained with the New York State Division of Vocational Rehabilitation and social agencies, visiting nurse services and other agencies concerned with the handicapped to insure continuation of the rehabilitation after the patient's discharge from the hospital as may be indicated.

Out-patient physical rehabilitation after the patient's discharge from the hospital as may be indicated.

Out-patient physical rehabilitation service is integrated with the in-patient service in order to insure continuity of supervision.

In our planning of development of Rehabilitation services we have profited extensively from the experience of the Department of Physical Medicine and Rehabilitation at Bellevue Hospital and have had the benefit of the inspired guidance of Dr. Howard A. Rusk.

The pattern of the program adopted for our general and special hospitals and institutions have of necessity been modified to meet the needs of the patients concerned and has been conditioned by factors of physical space, equipment and personnel resources or there present lack.

Our program is admittedly in an evolutionary stage of development and much still remains to be done.

The Rehabilitation services of our Tuberculosis hospitals have profited by the earlier experience of the Municipal Sanatorium at Otisville, N. Y., and by recent developments in this field.

At the Triboro Hospital in Queens

a comprehensive rehabilitation program was organized in March 1946 with the cooperation of the Queensboro Tuberculosis and Health Association. It has been in successful operation since that time and is today regarded as a model for institutions of this character.

More recently a well-organized rehabilitation service has been established at Sea View Hospital.

An effective rehabilitation service is in operation at Kings County Hospital.

Manifestly the Rehabilitation program of a tuberculosis hospital must differ from that of a general hospital. The objectives and therefore the techniques are not identical and special knowledge of the nature of the disease is called for in rehabilitation personnel operating in this area.

A special problem is presented in the recent development of a Rehabilitation service at Goldwater Memorial Hospital. Here is the largest chronic disease hospital in our city, we are challenged by a concentration of 1600 patients suffering from a wide variety of disabling diseases and conditions of chronic character. One hundred beds (equally divided between males and females) have been set up as a special rehabilitation service. Specialized personnel have been provided and equipment is available for the effectuation of a program which will be followed with interest by everyone in the field of medicine. This is one of the most challenging areas for the testing and proof of value of an all-out attack upon the ravages of chronic disabling disease.

In our custodial institutions which house Class C custodial patients who are for the most part the aged and infirm, emphasis has been placed upon diversional and recreational therapy. Special efforts are made to encourage patients in practices of self-helpfulness and to teach patients to live within the limits of their physical resources. 75% of these patients are 65 years or over and 14% are above the age of 85. It is obvious that vocational rehabilitation has little place in the program for the age group but encouragement is given to the reactivation of old skills and to the acquirement of new ones for di-

(Continued on next page)

(Continued from preceding page)
versal purposes.

Metropolitan Hospital and City Hospital have well developed programs of rehabilitation. The affiliation of these departments with the New York Medical College for teaching purposes has had a vitalizing influence upon the interest of visiting and house staffs in this important branch of medicine. Both of these hospitals are however handicapped by the lack of ward space necessary to establish a Rehabilitation ward service.

Our plans for the Metropolitan Hospital Replacement which have progressed to the final drawing stage and acquisition of a site at 97th Street and 1st Avenue includes ward accommodations for 75 male and 33 female patients (a total of 108 beds) for the establishment of a Rehabilitation ward service. In addition ample provision has been made for classrooms, craft shops, testing rooms and exercise gymnasium, together with physio therapy and hydrotherapy services.

These centralized facilities will serve both the out and in-patient Rehabilitation services.

The City Hospital replacement to be located at Broadway and 41st Avenue in Queens, provides accommodations for 80 rehabilitation ward patients, equally divided between males and females.

This hospital will be served similarly to the Metropolitan Hospital Replacement by facilities for the common use of the out-patient and in-patient Rehabilitation services.

The Bird S Coler Memorial Hospital and Home, now rising at the north end of Welfare Island will accommodate 2000 Class C chronically sick patients half of whom will be ambulatory; the other half bed or bed-side cases. Provision has been made in the planning of this hospital for extensive rehabilitation facilities. The program for this institution may require modification, however, based upon the experience which will emerge from the current study of rehabilitation of patients suffering chronic illness in progress at the Goldwater Memorial Hospital.

In our other general hospitals, physical therapeutic facilities and occupa-

tional therapy services are available in varying degree. A step in the direction of coordinating these facilities into Departments of Rehabilitation and Physical Medicine has been made and they are functioning with varying degrees of efficiency. The problem of medical staff interest and education in the benefits of a coordinated rehabilitation service is being met by demonstrations and indoctrination. The activating mechanism in a successful program is usually to be found in enthusiastic and intelligent leadership and as yet such leaders are few in number.

It is only possible to touch briefly upon the efforts at psychosomatic rehabilitation in our hospitals. The value of an effective mental hygiene service in a comprehensive rehabilitation program is well established.

A neuropsychiatric staff should be available to the rehabilitation services of general, tuberculosis and chronic disease hospitals and should function in both the in and out-patient departments.

Such a staff should provide consultative service and administer individual and group therapy to patients suffering from psychosomatic disorders of profound emotional disturbances.

It should be emphasized that such a service in rehabilitation, both in cases which are purely psychosomatic in character or where psychosomatic disorder may complicate or affect organic disability.

Our plans for future hospital construction incorporate facilities for psychosomatic patients in all general and chronic disease hospitals. Psychosomatic rehabilitation will find an important role in all of our hospitals.

At the present time, mental hygiene clinics operate on both day and night schedules in Bellevue, Kings County, Queens General, Harlem and Morrisania Hospitals. The demand for this type of service already exceeds our resources and it is planned to provide for the expansion of these facilities.

The ultimate range of rehabilitation has not been completely explored. The variety of skills required to effect such a program has created problems of recruitment, training and establishment

of standards of compensation which have not yet been entirely resolved.

Existing conditions of overcrowding in our hospitals and limitations of funds in the recent past have slowed our progress in the development of these important services. We are constrained within the fixed perimeter of absolute hospital plants designed before this age of enlightenment.

Happily our newer construction and hospitals in the planning phase will not suffer for lack of adequate physical provision for this important therapy. Our current budget provides for expansion of rehabilitation services wherever lacking and we are progressing rapidly towards a goal that gives promise of hope for many who were previously without hope and restoration to a useful and happy existence for many who had come to believe that they are destined for the scrap pile.

Operation "human salvage" is under way.

NEWS

(Continued from page 9)

Posture and Nursing, a handbook by Jessie L. Stevenson which sells for 50c and may be obtained from the National League of Nursing Education, N. Y., is of special interest to nurses and therapists. This booklet assists hospital personnel to apply the principles of posture and body mechanics in all daily activities.

Attention: Physical Education Personnel and trained Recreational workers seeking employment. Vacancies exist in Illinois State psychiatric hospitals, schools of mental defectives, children's and correctional institutions. These positions are Civil Service which offer career service with opportunity for advancement. The State of Illinois offers its employees an excellent retirement and insurance plan. Maintenance available if desired. For further information contact the editor.

about it. I think I'm pretty lucky to have what I have. I know lots of fellows who didn't get by nearly as good as I did."

The primary consideration, it would appear, is the general emotional stability of the individual. If he is able to accept his physical disability, and view it objectively, making it but one of the many components of personality rather than the predominating factor, his problems of social adjustment, although admittedly greater than those of the able-bodied, are still not overwhelming. Unfortunately, the emotional impact of disability is such that many persons do not possess the emotional stability to withstand the sudden shock of blindness, paralysis or other physical disabilities.

The attitude of the physically handicapped individual toward his own disability is also conditioned by the attitudes of those with whom he comes in contact. Ironically, such attitudes vary in different parts of the world. Facial scars in some cultures of Africa are such marks of distinction that wounds are self-inflicted. The same was true of duelling scars in pre-World War I Germany. Yet, here in the United States, persons with similar disfigurements suffer discomfort and spend money for their repair by plastic surgery.

Traditionally, the North American Indians, as well as many other groups, left those who were old and feeble to die by the wayside in order that they would not impede the mobility and safety of the tribe. Today, adequate care of the chronically ill constitutes one of the major medical and social problems of our times.

To the ancient Hebrews, illness and physical disability marked a person as a sinner—he was punished and was atoning for his wrong doings. Disability to the ancient Greeks, on the other hand, was not a sign of sin, but of inferiority. The early Christians, however, looked upon sickness and disability as a way to grace.

One of the great social values of the war was a more widespread social acceptance of physical disability. The disabled veteran was in the spotlight, and in our sincere desire that the disability of social rejection should not be added to the physical loss that had been incurred in our defense, we rapidly swung the pendulum to the side of social acceptance of the disabled. The insight and understanding gained through the films "The Best Years of Our Lives" and "The Snake Pit" are recent examples. No one seeing these performances could help but gain an objective understanding that it is not pity but acceptance and understanding which the physically and emotionally handicapped seek.

On many occasions the suggestion has been made to the motion picture industry that the utilization of physically handicapped persons in screen roles, not as stars, but in the same proportion and roles that we find them in everyday life, would aid in combating the curiosity and social rejection which is too frequently displayed toward the person who deviates from the normal physically.

Regardless of the various viewpoints of the psychiatrists and psychologists those who have worked closely with the physically disabled know that having once made the emotional adjustment to their disabilities, they possess a depth of understanding, patience and tolerance which is rarely found among those who have not endured the hardship of physical disability. They have been forced to discard the superficial and to find the fundamentals.

We who work with the physically handicapped can gain much from them not only in the techniques of physical rehabilitation but in developing our own patience, tolerance and understanding.

Howard A. Rusk, M. D.
Eugene J. Taylor
New York University College of Medicine
The New York Times

(Continued from page 14)

Dear Editor:

I have just received a June copy of the Journal of the Association for Physical and Mental Rehabilitation and I am writing to tell you how much improved I find the Journal. The format is, in my opinion, definitely superior to the previous format and in addition I like very much the inclusion of articles by physicians who give various points of view about these problems of physical and mental rehabilitation. I do not know who is responsible for the changes but please express my congratulations to those who are responsible.

I foresee a very bright future for the Journal and for the field of corrective therapy in general with such aggressive leadership as is shown not only in the Journal but also at the recent convention.

Very truly yours,

H. L. FLOWERS, M.D.

Chief, Neuropsychiatry Service
Bronx V.A. Hospital

Dear Editor:

As you may know, we have over five hundred children from the pre-school age through young adults, who live in twelve separate residential boarding schools in this area. There is also the Devereux Ranch School in Santa Barbara, California. These children range in capacities and represent both educational and emotional problems. We have always considered the physical aspect of our therapy program as most important and we try to incorporate this into the regular daily activity which is supervised by the building staff and our resident staff of physicians, psychiatrists, psychologists and social worker.

We would be glad to hear of anyone who would be interested in this work with our children. If they would write to us directly, giving their background and experience, we would be glad to contact them for possible interviews.

Sincerely yours,

Robert G. Ferguson
Educational Psychologist
Devereux Schools
Santa Barbara, Calif. and
Devon, Pa.

CONSTITUTION AND BY-LAWS OF THE ASSOCIATION FOR PHYSICAL AND MENTAL REHABILITATION

Preamble

The rehabilitation of physical and mental handicap — to bring about a greater unity of purpose and correlation with related therapies in cutting down the number of hospital days, making social and physical adjustment in and out of the hospital.—(Pending—committee appointed to revise and prepare final preamble.)

Constitution

ARTICLE I—NAME

Section 1—The organization shall be called the Association for Physical and Mental Rehabilitation

ARTICLE II—AIMS

Section 1—(a) To employ corrective exercises for physical correction and mental adjustment.

(b) To Develop confidence of the patient in his ability to improve socially at the point where he can participate with others in group activity. (Committee appointed for further study.)

(c) To modify and diversify activities so as to awaken the patient's interest and redirect it into constructive behavior.

(d) To provide individual attention for the patient who cannot adjust to a group activity. (Committee appointed to work on additional aims.)

ARTICLE III—MEMBERSHIP

Section 1—The Membership of the Association should be designated as active, associate, honorary and auxiliary.

ARTICLE IV—GOVERNMENT

Section 1—The business of the Association shall be conducted by an Executive Board and a Representative Assembly, each constituted as hereinafter provided.

ARTICLE V—PUBLICATIONS

Section 1 — The official publication shall be called the Physical and Mental Rehabilitation Journal.

(a) Individuals may subscribe to the Journal on a yearly basis for the payment of the subscription rate as established.

(b) The annual subscription rates for libraries, colleges and universities

shall be \$3.00 and shall run from date of subscribing to one year.

ARTICLE VI—AMENDMENTS

Section 1—The Constitution may be amended at any meeting of the Representative Assembly or by mail vote as hereinafter provided. An affirmative vote equivalent to two-thirds of total membership of the Representative Assembly shall be necessary for amendment. No mail vote shall be valid beyond thirty days after official notification. Amendments shall be published not later than the third issue of the official publication following approval of amendments.

By-Laws

ARTICLE I—MEMBERSHIP

Section 1—Membership in the Association shall be designated as Active, Associate, Honorary and Auxiliary.

Section 2—Active members shall consist of all persons professionally engaged in Corrective Physical and Mental Rehabilitation or persons qualified to engage in this type of work. (Professional Standards Committee appointed).

(a) To be eligible for active membership an individual must possess a degree from an accredited college or university with a major in Physical Education, plus a minimum of a year's experience under a doctor in a program of physical rehabilitation, mental rehabilitation or reconditioning.

(b) Or be a graduate of a course leading to a Master's degree in the field of Physical or Mental Rehabilitation, subject to approval of Professional Standards Committee.

Section 3—Associate members shall be those persons of a professional status who are interested in rehabilitation, but are not eligible for active membership.

Section 4—Honorary members may be persons outside the professions of Corrective Physical and Mental Rehabilitation, but elected to the membership on the basis of unusual interest and meritorious service in these or closely related fields. Honorary membership nominations may be initiated by any member of the Association at the Professional Standards Committee, which in turn shall present the nominations to the Representative Assembly for pre-

sentation to the general membership at the Annual Convention, where a two-thirds majority vote of the active membership shall be necessary for approval.

Section 5—An auxiliary member is considered to be one who is presently engaged full-time in Physical Rehabilitation but who does not meet the full active membership requirements; or students who are in the process of attending approved schools for rehabilitation. (Subject to approval of the Professional Standards Committee.)

Section 6 — Active, Associate and Auxiliary members shall be approved by the Professional Standards Committee. The Secretary may act for this Committee but will refer questionable cases to the Professional Standards Committee for approval.

Section 7—Only active members shall have the right to hold office or vote in the election of members for the Representative Assembly, Executive Board and Officers, as provided.

Section 8—The annual dues for active members shall be \$5.00; associate and auxiliary members \$3.00. The annual dues for all members shall cover a period of a calendar year, that is, a full year from the date of payment for subscription.

ARTICLE II

REPRESENTATIVE ASSEMBLY

Section 1—The Representative Assembly shall consist of three elected members of each area, plus the Executive Board.

(a) The Executive Board shall consist of the following elected officers: President, President Elect, Three Vice Presidents, Secretary, Treasurer, Director of Publications and Research and the Immediate Past President.

(b) Areas will be defined as follows:

Area 1—Maine, New Hampshire, Vermont, Mass., Conn., N. Y. and R. I.

Area 2—New Jersey, Delaware, Pennsylvania, Maryland, Virginia, West Virginia, Ohio, Kentucky, Indiana and the District of Columbia.

Area 3—North Carolina, South Carolina, Georgia, Florida, Alabama, Tennessee and Mississippi.

Area 4—Illinois, Wisconsin, Iowa, Nebraska, South Dakota, North

Dakota, Montana, Michigan and Wyoming.

Area 5—Colorado, Kansas, Oklahoma, New Mexico, Texas, Missouri, Arkansas and Louisiana.

Area 6—Arizona, Utah, Idaho, Washington, Nevada, Calif. and Oregon.

Section 2—The members of the Representative Assembly of each area will be elected by ballot, conducted by each Area Chairman of the Membership Committee within thirty days after the annual Convention.

(a) The Area Membership Chairman shall be appointed by the President of the Association.

(b) The term of office of the Representative Assembly will terminate at end of subsequent Convention.

Section 3—It shall be the duty of the Representative Assembly to effect all changes in the Constitution and By-Laws; to elect the President Elect and the Director of Publications and Research; to initiate such business as it seems desirable; and to exercise veto power over action taken by the Executive Board upon two-thirds vote of those present at an official meeting and other business as hereinafter provided.

(a) It shall also be the duty of the Representative Assembly to review the members of the Advisory Board and the Editorial Board and to effect changes as it deems necessary.

Section 4—The Secretary shall keep a record of the proceedings of the Representative Assembly and shall make a report at each meeting and at the National Convention. He shall notify each representative at least sixty days before its annual meeting.

Section 5—The annual meeting of the Representative Assembly shall be held at the time and place of the National Convention. Special meetings may be called by the President, or by the written request of a majority of the Representative Assembly.

Section 6—Two-thirds or more members of the Representative Assembly shall be held at the time and place of the National Convention. Special meetings may be called by the President, or by written request of a majority of the Representative Assembly.

Section 6—Two-thirds or more mem-

bers of the Representative Assembly present, in person or by proxy, shall constitute a quorum for transaction of business. This proxy is not transferable; it must name in writing to the President, the specific person or persons authorized to cast the vote. Each member shall designate his own proxy, and not more than two alternates, listing them in order of preference. If a proxy is issued to more than one person it thereby becomes automatically cancelled.

Section 7—Members of the Association may attend all Representative Assembly meetings without vote. By majority vote of the Representative Assembly, a visitor may address briefly the members of the Assembly.

ARTICLE III—EXECUTIVE BOARD

Section—The Executive Board shall be the President, President Elect, Three Vice Presidents, Secretary, Treasurer, Director of Publications and Research, and the immediate past President.

Section 2—It shall be the duty of the Executive Board to hold their representative elected offices and conduct official business of the Association as members Representative Assembly.

ARTICLE IV—OFFICERS

Section 1—The officers shall consist of the President, the President Elect, Vice Presidents, the immediate past Presidents, Director of Publication and Research, Secretary and Treasurer.

Section 2—The President Elect shall be elected annually by the Representative Assembly at the regular annual meeting. The President Elect shall automatically succeed to the office of the President at the conclusion of the next annual meeting.

Section 3—The President shall act as Chairman of the Representative Assembly, Executive Board and Conventional Committee of the National Convention. The President will also act ex-officio on all Committees. The President may appoint committees and hold office one year.

Section 4—The President Elect shall act for the President in his absence. In case of death or resignation of the President, the President Elect shall succeed him for the unexpired term.

Section 5—Expenditures up to \$50. may be approved by the President ex-

cept for publications which are routine. Expenditures in excess of this amount must receive the approval of the majority of the Executive Board. The publication of the official journal does not fall in this category.

Section 6—The President shall appoint annually a Certified Public Accountant, who shall audit the books and accounts of the Treasurer. The report shall be brought forward at the meeting of the Representative Assembly.

Section 7—The President shall appoint the following Committees:

Professional Standards, Membership, Convention, Publicity, Constitution, Honorary Membership Committee, and any other special committee that he may deem advisable.

ARTICLE V

ELECTION OF OFFICERS

Section 1—For all officers other than President Elect and Director of Publications and Research, there shall be a nominating committee consisting of a Chairman, to be appointed by the President, and one representative from each area of the Association selected by the Chairman.

Section 2—The following officers will be elected at the Annual Convention, by a majority vote of the active membership: Vice Pres., Sec., and Treas.

Section 3—No one member shall hold two elective offices simultaneously.

Section 4—All elections shall be conducted by closed ballot.

ARTICLE VI—CONVENTION

Section 1—The National Convention shall be held annually.

Section 2—The National Convention site shall be selected one year in advance by the majority vote of the Representative Assembly, and upon invitation of a city.

ARTICLE VII—AMENDMENT

Section 1—These By-Laws may be changed at any meeting of the Representative Assembly, or by mail vote of the Representative Assembly. An affirmative vote equivalent to two-thirds of the total membership of the Representative Assembly shall be necessary for change. No mail vote shall be valid beyond thirty days after official notification. Amendments shall be published not later than the third issue of the official publication following approval of the amendment.

Section 2—Any active member of the Association may submit to the Officers any suggestions for amendments to the Constitution and By-Laws.

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LOCATION

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(REQUIRED—A MAJOR IN PHYSICAL EDUCATION)

TRAINING IN PHYSICAL REHAB.

EXPERIENCE IN PHYSICAL AND/OR MENTAL REHABILITATION

(Required—One Year Under Direct Supervision of a Doctor of Medicine)

CONTRIBUTION

i.e. Publications, Studies, Surveys or Research in the field of Physical or Mental Rehabilitation

REFERENCES: 1.

Name

Position

Location

2.

Signature of Applicant

NOTE: REQUIREMENTS LISTED ABOVE ARE FOR ACTIVE MEMBERSHIPS

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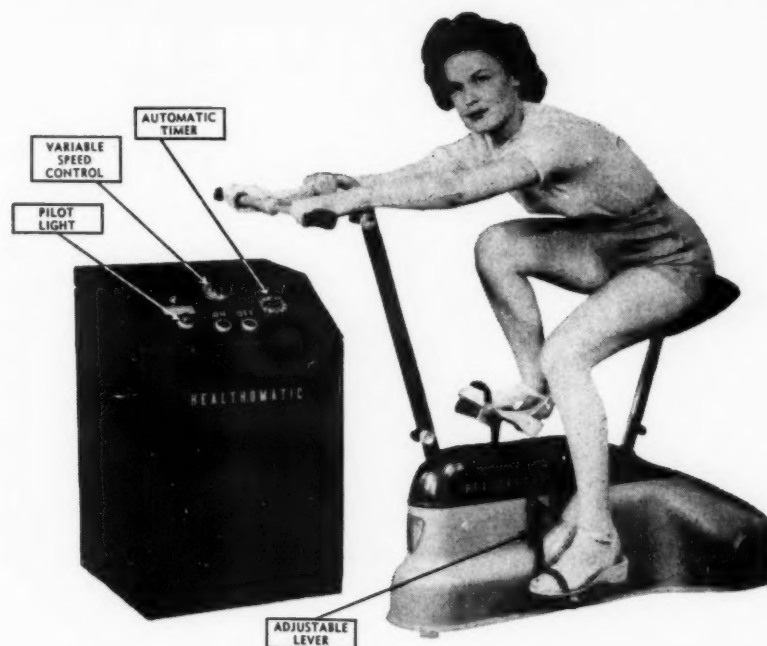
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